



# THE MODERN HOSPITAL

*A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services*

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## PRESIDENT MACEACHERN OUTLINES FUNCTIONS AND AIMS OF A. H. A.\*

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THIS is the twenty-sixth annual conference of the American Hospital Association. Last year we celebrated the twenty-fifth or silver jubilee anniversary, and on that occasion President Bacon gave us a most complete and interesting history of the association which convinced all beyond a doubt of the continued progress that the association had made during the first twenty-five years of its existence. This history is recorded in the last annual proceedings.

### Cooperation Essential for Success

Through your action and consideration I have had the honor of presiding over the association this twenty-sixth year of its existence. This I regard as the highest honor any person can have in the hospital world. For this let me express my sincere thanks and appreciation.

Like my predecessors, I suppose, and as all presidents assuming office should do, I "took stock." Recorded data readily available showed many accomplishments in the past. Two questions immediately confronted me: First, what is the broadest scope or functions this association is expected to render and can render? Second, is the association at present fulfilling the expectations and demands of the field? These two questions are vital and require careful thought.

The first question more or less baffled me, as I seemed unable to know where to draw the line. One thing after another came to my mind as to what the association could do, and to make a long story short I pictured a wonderful future

for it—a future best described and characterized as one of unlimited service to the field in the interests of the progressive development of the hospitals of America. It should be the all-in-all, through-and-through service organization of the entire field.

### How the Association Should Function

I would assign seven definite functions to the American Hospital Association as follows:

- (1) *To serve as a means of intercommunication and cooperation among the hospitals of the United States and Canada.*
- (2) *To increase the efficiency of all hospitals in the United States and Canada by establishing and maintaining the best possible standards for hospital service.*
- (3) *To stimulate and guide intensive and extensive hospital development in the United States and Canada.*
- (4) *To develop on the part of hospitals in the United States and Canada a sense of responsibility to the community in respect to education in health and hospital matters.*
- (5) *To keep the people of the United States and Canada informed concerning hospital problems, and in this respect, to assist hospitals generally in dealing with governmental bodies—federal, state or municipal.*
- (6) *To formulate from time to time suggestions for additions to or changes in legislation affecting hospitals.*
- (7) *To contribute to the hospital field information and findings for the good of all hospitals.*

The second question was equally difficult to answer. My conclusion was that the association is

\*Abstracts of address delivered before the twenty-sixth conference of the American Hospital Association at Buffalo, N. Y., October 6 to 10, 1924.

not able to meet all the expectations and demands of the field, but is doing so insofar as the headquarters staff and finances will permit. With the limited resources at hand, and in the face of ever increasing demand, splendid service is being rendered.

### Momentum and Finances Needed

What, then, is needed to more advantageously meet the expectations and demands of the field generally? Two things—momentum and finances—both of which come from increased membership. Hence the decision to launch a general membership campaign, complete information regarding which will be given to you in the special membership campaign bulletin and at the membership campaign booth.

In a short time the United States and Canada was organized into thirty-two areas or regions, for each of which a regional campaign committee was appointed to cooperate with headquarters in this particular work. Each committee has a convener and number of workers varying from three to fifteen in number. Already these committees have pushed the work vigorously. The campaign has been under way for the last few weeks, and the results are most gratifying. I am very pleased to announce that Dr. Lewis A. Sexton, superintendent, Hartford Hospital, Hartford, Conn., and chairman of the membership committee of the association, has accepted the general chairmanship of this campaign.

Let me urge the association and the trustees vigorously to carry on this campaign during the coming year and continue it till all the new members possible are secured. We cannot progress and develop without momentum and finances. Let the whole field seriously take up this movement in a unanimous and energetic manner throughout the entire year. The success of the campaign means a great deal to every hospital, inasmuch as the association will be in a position to do greater things for them.

Simultaneously, and closely linked up with the general membership campaign, came the idea of a completely organized hospital field—a field organized for service, for protection and for more scientific progress. I fully believe that one of the outcomes of the membership campaign will be the hastening of the complete organization of the entire hospital field—national, state and provincial or local.

On May 13th last, the day following National Hospital Day, the association officially took over the National Hospital Day movement, which has become so firmly rooted in the minds and hearts of the people throughout the United States and

Canada. National Hospital Day, a popular movement, and now almost world-wide in its recognition, is now a new activity of the association. The association will continue to put forth strongly the tenets of this day. It is well worth while and, when finances permit, I hope the association will appoint a full time director of this day and field publicity generally. At the present conference you will note a beginning has been made in this respect by the establishing of a publicity booth under the direction of Ralph W. Keeler, counsellor in publicity for the Board of Hospitals and Homes of the Methodist Episcopal Church.

More and more information, technical, administrative and legal, is being constantly demanded of the association. To serve the field properly we must be in a position to give the information promptly and accurately. Many of the problems for solution are intricate and convince me that the addition of a technical staff at headquarters is one of the pressing needs at present. With increasing strength and finances I hope more technical and advisory personnel can be added from time to time. What a help such a staff of workers could be to the field by visitation to individual hospitals having problems—administrative, educational, technical, legal or other—to solve. Let us be better prepared to give all hospitals, not only a correspondence service on their inquiries, but, when necessary, a personal on-the-spot service, so we may more clearly understand their problems.

The association has been fortunate in the past in having working committees studying many problems pertaining to administration and technical matters encountered in the hospital field. These committees have worked hard during the year; they have given their time and efforts voluntarily to the work.

### Suggests Addition to Organization

The relation of state and provincial associations to the American Hospital Association is unsettled at present. Various attempts have been made to solve this problem and devise ways and means for a practical and workable affiliation. So far, I believe, no successful solution has been reached. I expect this will be a matter for discussion at the present conference.

In considering the matter carefully I, personally, feel the time has arrived when we must seriously think of introducing what might correspond to the house of delegates or representatives in other national organizations. Such a body has been found to be an acceptable and necessary part of national, state and provincial organizations of various kinds. This, in addition to our present

organization, would provide a more representative and well balanced opinion on matters of interest to the association, and would furnish the link we are now looking for between the American Hospital Association and the state and provincial units. This presupposes that each state and province has its own organization in order that each may appoint a representative or representatives to the house of delegates or representatives—the number of such delegates or representatives to be determined in proportion to their respective membership in the American Hospital Association. In this way affiliation desired could be obtained and membership in the association stimulated.

### Practical Standards Developed

The association has made a good start towards the development of practical standards, as you will all agree when you study the reports to be submitted by the various committees. The report submitted by Miss Margaret Rogers, on behalf of the committee on general furnishings and supplies, illustrates what can be done in this respect. Miss Rogers has accomplished a splendid piece of work in the standardization of hospital bed sizes. In this she had the utmost cooperation of the division of simplified practice, United States Department of Commerce, Washington. It will serve the hospital field in saving the hospitals, not only a great deal of time and thought, but no doubt, money as well.

The hospitals are looking for standards in equipment, supplies, organization, procedure and various attached services. A vast field remains to be covered. They know that through proper practical standards they can save time and money and do more efficient work. The field is large and our association, now that it has made a start, should continue to develop more of these standards.

Administration and service standards are much needed. They must be practical and uniform in nature. Give the hospital a minimum standard and with a guiding service it will soon develop maximum standards. The association can render a real service to the field in developing and submitting standards of this kind from time to time.

I believe the association should develop broader relations with all allied organizations and groups. The United States and Canada have numerous organizations of this kind, many of them closely related and often identical with each other in activities. We need a closer contact for better understanding of each other's functions so as to present overlapping or omissions through better cooperation and coordination.

Without intending to discriminate, I can mention the need and desire for closer relations and

contact with the National Tuberculosis Association and the American Psychiatric Association. These two organizations are interested in two groups of cases, tuberculous and psychiatric respectively, which concern the general hospital and today present administrative problems. The more specialized or concentrated data collected by special organizations, would be, I am sure, of great value to our association. I also hope that at least the interchange of representatives at functions of this kind will be carried out. Let us make every effort to promote closer relations of this kind in the future.

I would recommend closer relations with the hospitals of the United States Army, the United States Navy, the United States Public Health Service, the United States Veterans' Bureau and the Soldiers Civil Re-Establishment of Canada. This contact would be of mutual advantage.

### Eliminate the Unethical

I feel that the association has arrived at a time when there is need of laying down a code of ethics for hospitals. I receive complaints frequently of hospitals doing things which are irregular and tend to commercialism. Is not the association the body to appeal to for correct guidance? Why do hospitals admit fee-splitting surgeons or those practising methods generally regarded by the profession as unethical, unsound, unscientific and commercial? These practices are not considered compatible with the care of sick human beings. Many such instances come before the American College of Surgeons in its hospital work, and not infrequently we find the hospital loath to take action because the client brings them revenue. We must eliminate irregulars, the unethical and commercial element from our hospitals today, primarily, of course, for the sake of the patient.

It is deplorable to think that politics creep into our hospitals, which may immediately ruin any institution. There is no place in the world where politics should be banned more than in a hospital. Let the association take a firm stand on this and go on record as strongly opposed to it.

In this connection I want to call your attention to MY PLEDGE AND CREED, recently published in THE MODERN HOSPITAL. This Pledge and Creed is the result of much thought—that is why it is so full of beautiful interpretation. I would like to see the spirit of this permeate all institutions. I wish My Pledge and Creed could be adopted and put into universal effect throughout every hospital in America. What a great change would come over many of our institutions. I would therefore recommend that the association take more interest in hospital ethics, establish a

code of ethics, and adopt for universal use MY PLEDGE AND CREED.

Closely related to the question we have just been discussing is the adoption by the association of some standard of qualifications for membership. At present I believe there is an unwritten standard exercised by the executive secretary, the board of trustees and the membership committee. However, I believe it would be greatly to our advantage if this standard were more generally known. It would, I feel sure, tend to stimulate better ideals and ethics.

### Membership an Important Credential

Membership in the association must always be carefully guarded and be kept on a high plane so as to carry with it credentials worthy of universal recognition and confidence. The time has now arrived when the first information sought about any institution or hospital executive making a request or asking for consideration is, whether or not that institution or hospital executive is a member in good standing in the American Hospital Association. Indeed, this question will be asked more and more frequently in the future. The certificate of membership hanging in the front entrance of your hospital or in your office carries with it a recognition well worth while.

The matter of training hospital executives has been before this association and the board of trustees in the past, but very little progress has been made. No doubt the committee of the association dealing with the matter will bring in an encouraging and acceptable report. As time passes the need for this becomes more urgent and we, as an association, must take definite action. The field needs trained hospital executives. It seems to me that the association itself should take a more active part than it has in the past in advancing this cause.

Related to the matter of training hospital executives is that of providing refreshing or observation courses for those already engaged in hospital work of any kind. Cannot the large hospital centers organize hospital councils as some of the cities have already done? The purpose of such a council should be, not only to promote hospital interests locally, but to take stock of their facilities and to organize them for teaching and demonstration purposes. When the busy hospital executive comes to the large city to visit hospitals is there not some organized information service that he or she can get as a guide as to where to go to secure that information to the best advantage? Every hospital, possibly, has some outstanding feature worthy of demonstration. The hospital executive making a tour is much handi-

capped because of the lack of organized information indicating what hospitals to visit, how to get to these hospitals, who to ask for and what to see to the best advantage in each particular case. No doubt the hospitals in any of our larger cities cover the entire range of facilities, organization and procedure worth while seeing. An abundant amount of valuable information can thus be made available for such observation or refreshing courses so often participated in. Possibly arrangements can be made with the university to put on a short course in administration during the summer months, as was successfully done at Temple University, Philadelphia, this year.

### Association Should Train Executives

I would, therefore, recommend that the American Hospital Association take into consideration more seriously the matter of training hospital executives and the formation of organized observation, refreshing or post-graduate courses for hospital personnel in the larger cities of the United States and Canada, using the abundant facilities available for this purpose.

Through the deliberations of this conference and particularly through the exposition, you acquaint yourselves with improved methods of hospital management, increased efficiency and better means of economy. You all benefit in many ways, but there is one in common, and that is the renewed enthusiasm you will carry back when you return to take up your respective duties. You will go back better hospital administrators and workers. Regardless of what institution you come from, no matter what size, kind or location, all of you have the same purpose and that is, the best care of the patient. We are glad to have so many of the smaller hospitals represented at this conference. The convention will endeavor to keep these institutions in mind particularly and its discussions to the solution of their problems. The convention balances up the discussions and deliberations so that uniformity of thought and procedure relative to hospitals may be obtained, but in this each institution must retain its own individualism and work out its own problems by applying some of the general principles presented at this conference.

### TO SUMMARIZE:

(1) The association has had a good year, noticeably characterized by increasing interest, activity and cooperation on the part of the hospital field generally.

(2) The association has important and definite functions to perform in the best interests of the hospitals of the United States and Canada.

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## CONCERNING HOSPITAL ORIGINS\*

BY S. S. GOLDWATER, M.D., PRESIDENT, AMERICAN CONFERENCE ON HOSPITAL SERVICE; DIRECTOR, MOUNT SINAI HOSPITAL, NEW, YORK, N. Y.

**T**O MAKE a drama, said the elder Dumas, a writer needs only one passion and four walls. In truth great dramas have been created out of scantier materials. Can one conceive of a greater drama than that which is enacted each time a human being is snatched from the jaws of death, or rescued from the misery of lifelong suffering? For the creation of such a drama a single powerful emotion, pity or love, suffices; the walls of a hospital may be used as a setting, but ages ago the Good Samaritan showed that a dramatic effect powerful enough to dwell in the memory of mankind forever, may be achieved without them.

Thoughts and emotions lie at the root of all human institutions, hospitals among the rest; and it may be interesting to consider the nature of the ideas from which hospitals have sprung. How easy the task, if every hospital had its historian! Satisfactory hospital histories are rare, but in one that happens to be at hand we may observe how a hospital germinates in the mind of its founder.

In a passage entitled "Johanna Chandler's Resolve," B. Burford Rawlings, historian of the National Hospital for the Paralyzed and Epileptic, of London, tells us that a journeyman carpenter, who lived near Miss Chandler, "was struck down at his work and was carried home to be nursed by his wife, a wreck of a woman in the last stages of consumption, with no knowledge of nursing, and already encumbered by the care of four small children. Miss Chandler tells us that she never forgot the scene of that desolate home, and we can well understand how the impression deepened when she found that among all the hospitals of London not one would open its doors to a case of that sort, that the splendid efforts of philanthropy, so potent and far-reaching in most directions, stopped short here, and that for the

medical treatment of the victims of paralysis and the many kindred affections of the nervous system, neither the metropolis nor any of the provincial cities made one iota of provision. 'God helping, I made the resolve', said Johanna Chandler, 'that I would devote my life to an endeavor to supply this want'." Within the four walls of the Hospital for the Paralyzed and Epileptic, thus begun, countless acts of devotion have since been performed, and the machinery which the generous impulse of Johanna Chandler set in motion, is still working wonders.

Although, to most of us, the hospital is a fairly definite object, its origins are various. At one end of the fertile field in which hospitals have taken root we encounter resolves like that of Johanna Chandler—thoughts illumined with gentle feminine sympathy. At the other extremity we encounter motives of a totally different quality. Shall we pay homage to the tyrannical millionaire who, brushing aside impartial and sensible advice, insists upon the erection of a monumental

### Underlying Motives

**M**OTIVES underlying the founding of hospitals yesterday and today were analyzed by Dr. Goldwater at the dinner session of the Buffalo conference. Pity, fear, human sympathy and religious zeal have been dominating factors in the establishment of hospitals of the past and present.

Although the financial problems attendant upon the establishment of hospitals today have often opened the door to the selfish motives of financiers who conceal their ulterior purposes under the veil of benevolence, the humanitarian impulse may be regarded as the dominant factor in the founding of most hospitals.

hospital which the community does not need and which it is unable to maintain? Shall a place be reserved in Valhalla for the covetous real estate shark who, concealed in the folds of a pseudo-philanthropic hospital organization, foists upon a city a site which he knows to be ill-adapted for hospital use? Shall we tamely and tacitly consent when physicians, with no better motive than personal aggrandizement, form a society to assist them in needlessly duplicating existing hospital facilities? Such perversity of motive in hospital founders is, unfortunately, not rare. A more curious example of distorted vision is that of the well-to-do citizen who, according to his neighbors, sought to outrage the feelings of his widow, a woman known for her strait-laced views, by bequeathing his fortune for a hospital for the care of unmarried mothers. Little did he realize that

\*Paper read before the twenty-sixth annual conference of the American Hospital Association, Buffalo, N. Y., October 7, 1924.

hospitals, like individuals, have the power of adapting themselves to their environment, and that in less than a dozen years, the hospital that he endowed would find a way to satisfy more urgent local needs.

To review the whole history of hospital origins would take us too far afield, and might challenge disastrous comparison with the imposing complications of encyclopedias. That some, at least, of the races of antiquity were concerned for their sick is well known. Christianity intensified the emotions of love and pity and thus gave a new impetus to the establishment of hospitals; but as far back as the third century B. C. (to cite a single ancient example) King Asoka, in India, decreed the establishment of hospitals, just as the sovereign people of Los Angeles County, Calif., did a few months ago, when they authorized a bond issue for the erection of a new county hospital. The seat of political authority changes, but the beneficent hospital idea persists.

### Fear a Factor in Creating Hospitals

Fear, which has played countless scurvy tricks upon mankind, often paralyzing the hands of would-be saints and sinners, is, oddly enough, one of the most common causes of the creation of hospitals. When a modern health department seeks to obtain an appropriation for a hospital for contagious diseases, it employs all the tricks of the propagandist to stampede an alarmed populace into an act of self-preservation. This motive for the creation of a hospital is not a new one. In his delightful history of the Pennsylvania Hospital, Dr. Thomas G. Morton tells us that in the year 1743, fully eight years before sundry inhabitants of Pennsylvania petitioned the provincial Assembly for permission to establish the Pennsylvania Hospital, the pest house on Fisher's Island was purchased by the authorities for a quarantine station for the shelter and isolation of persons arriving from sea with epidemic diseases. This public provision for the "sick and distempered immigrants," says Dr. Morton, "had in all probability been inspired, not so much by a tender concern for their welfare, as by the desire to keep such persons out of the city, and thus isolating them, to prevent the introduction of contagious diseases."

There exists among us a type of hospital whose confessed motive is the personal profit of its promoters, usually physicians; I refer to the proprietary hospital, which, however, holds only a subordinate place among the hospitals of America. The leaders in the establishment of our philanthropic hospitals, whose role in America is a far more important one, are, as a rule, laymen,

not physicians. There is a strange contradiction in the fact that while physicians dare to aspire, through the establishment of a national ministry of health, to a commanding position in the government of the nation, they abandon to laymen, almost without a struggle, the management of the country's greatest hospitals. Now and then a request is made for medical participation in hospital management, but determined efforts to secure control are rare. Although Shakespeare speaks of "folly, doctor-like, controlling skill," the physicians of America fail to make effective use of so apt a slogan. Is it, one wonders, merely a case of fear of the money power? We moderns are accustomed to hear money talk with the voice of authority, but it is hardly conceivable that the learned members of the medical faculty mistake the metallic clinking of minted coin for the golden conversation of the gods. The meek submission of physicians to lay control of their most weighty affairs, must have a deeper meaning. Perhaps the absorbing character of the work of the physician, which demands so much accuracy and skill and such intense concentration on specialized mental and manual processes, steals away his imagination and his passion, qualities without which great institutions cannot be created or effectively maintained.

### The Promptings of Religion

Need one dwell upon the religious motives in hospital service? If a hospital is avowedly established in honor of the living God, can it falter in its work of human salvage while faith lasts? On a far lower plane of devotion, and yet not without a faint tinge of glory, are hospitals established in honor of mere earthly sovereigns. And in our own country, where religious zeal sometimes flags and where kings are unknown, hospitals are worthily inspired by a sentimental regard for the memory of parents, husbands, wives, children, and friends.

Sympathy for the sick is quick and contagious. In a certain city in Pennsylvania, many charitable enterprises resort to the city streets for the solicitation of funds. The fair solicitors swarm over the sidewalks, exchanging beautiful flowers, colored ribbons, and embossed buttons for money, and in this pleasant pastime, I am told, the hospitals fare better than any of their competitors—the children's hospitals best of all.

With the hospital idea as an ally, there is nothing that a slip of a girl cannot do. About a year ago, the brother of a Chinese girl student in a Western university, was accidentally killed. The lad was a medical student, and it had been his purpose to promote the practice of Western medi-

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cine in the family's homeland. The sister was inconsolable until the thought came to her that she would try to take her brother's place by erecting a hospital in the city where he had intended to practice. And so she began a tour of the States, calling upon Chinese alone for support. In a single year, this girl has collected more than a hundred thousand dollars, and in thirty-five states has organized societies pledged to the support of her cherished enterprise.

Where sympathy for a particular sufferer or group of sufferers results in an effort to organize a hospital, the effort is frequently directed in a special channel. We are all familiar with hospitals established for the exclusive benefit of mothers or infants; of cripples, incurables, the tuberculous, or lepers; or Italians, negroes, industrial workers, or soldiers. Frequently the special group whom the founders seek to benefit consists of their co-religionists. Indeed, sectarian hospitals are now all about us, a striking feature of American life; and so potent is the influence of environment that even the germ-proof Christian Scientists, strangers to all infirmity, may soon decide to establish hospitals of their own. At present Christian Scientists who resort to hospitals for the correction of the purely mental error of a broken bone, seem adrift in what Myers called the "interspace between faith decayed and faith re-risen."

For hundreds of years the greatest strength of an appeal for funds for hospital support lay in the poverty of the hospital's beneficiaries. Until recently the hospitals of England refused to accept any payment from a patient, lest the perfect purity of their charity be marred. In our country, today, a voice is heard throughout the land crying out for hospital accommodations not for the pauper, but for the middle class, whose need is paradoxically asserted to be even greater than that of the poor.

### Sympathy as the Basis of Appeal

How pitiable is the plight of the diseased in mind! I believe that genuine sympathy for these unfortunates, quite as much as personal dread of the consequences of their neglect, has rallied the American nation to the liberal support of hospitals for the insane. No longer is it necessary to present to legislatures, as did in 1751 certain petitioners in Pennsylvania, the pitiful picture of persons of unsound mind, "some of them going at large, a terror to their neighbors, who are daily apprehensive of the violences they may commit. And others are continually wasting their substance, to the great injury of themselves and families, ill-disposed persons wickedly taking ad-

vantage of their unhappy condition, and drawing them into unreasonable bargains."

### Hospitals Founded on Financial Motives

Financial and pseudo-financial calculations play a considerable part in the launching of hospital projects. Health officers appealing for departmental appropriations, have long been accustomed to make use of equations in which human life is set off against an assumed equivalent in dollars. In slave-owning days the comparison might have been allowed, but is it not high time for the economist, with his cold-blooded calculations, to withdraw from a sphere in which the body is regarded as something more than a cog in the mechanism of industry, devoid of spiritual meaning? The support of a hospital may indeed be good business, viewed merely from the standpoint of industrial efficiency, but the hospital whose thoughts are merely venal, whose activities are not suffused with uplifting emotion, does not merit a place in the company of the blessed. But to judge a hospital without full knowledge of the character of its work would be unfair—the quality of wine depends on its taste, not its label. Hospitals whose primary motive is financial profit, have done and are doing excellent clinical work, are alleviating misery, and in some instances are contributing notably to scientific research.

The pessimism of a recent essayist who speaks of the "illusion of advance" finds no echo in the alert and forward-looking hospitals which aim to make their contribution to human welfare by means of the intensive study of medical problems, and which believe in the reality of progress.

While scientific discovery is a familiar by-product of the progressive and well-ordered hospital which aims to save the life or lessen the sufferings of its patients day by day, these latter results, oddly enough, are often most effectively achieved incidentally to the work of the research hospital, whose scientific objective is quite remote from the well-being of its immediate guests.

The motives of the far-flung army of medical missionaries seem to be mixed in varying proportions. The primary object of the medical missionary is, presumably, to save souls, but I have visited missionary hospitals in which the medical ardor of the staff seemed to be greater than its religious zeal. In many parts of the world missionary hospitals, through the singular devotion of their staffs, are accomplishing marvelous results in circumstances and with equipment that would be scornfully rejected by our hospitals at home. In the presence of a woman doctor who, in a distant country and among an alien people, conducts single-handed a hospital of a hundred

beds, one is struck dumb with admiration. The far East has many such glorious women.

There is a sense in which missionary hospitals and military hospitals resemble each other, each being primarily concerned with something beyond and different from the cure of the individual patient. While one for purely military ends, seeks to conserve the man-power of an earthly state, the other strives with all its might to recruit souls for heaven.

Alice Meynell speaks of a friend who always "prayed temperate prayers and harbored probable wishes." The hospital founder is not always such a sweetly reasonable person. Fundamentally the goal of the hospital is unattainable, for if death be the enemy whom the hospital seeks to overcome, the aim of the hospital is no less than to confer immortality; it may force the enemy back, but crush him it never can. And yet the hospital struggles bravely on, showing how "the squalid story of human life upon this earth" may be "lit by amazing flashes of intelligence, of valor, of pity, of sacrifice, of love." Let us bow our heads in reverence to the memory of Father Damien, who succored the outcast leper; let us praise the gallant figure of Florence Nightingale, who made hospitals safe for the sick; let us be grateful for the presence among us today of a multitude of men and women, who without thought of self, dedicate their lives and their fortunes to the service of the sick, the halt, and the blind.

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(3) The ever growing demands for service made on the association require increased momentum and finances to meet them adequately.

(4) The increased momentum and finances adequately to meet the needs of the field can come only through a greatly increased membership—institutional and personal.

(5) The increased membership is now being secured through a well organized active general membership campaign carried on throughout the United States and Canada through the cooperation of thirty-two regional campaign committees.

(6) The membership campaign should be pushed forward vigorously till all the possible institutional and personal members eligible are secured.

(7) It is hoped and expected that the general membership campaign now being carried on will inspire much needed complete organization of the entire hospital field for protection and more progressive development generally, as well as for economic and scientific reasons.

(8) The entire hospital field of the United

States and Canada should be covered by a complete, closely inter-related organization, consisting of international, state or provincial, and local units, each having its own respective functions.

(9) National Hospital Day celebration, through the courtesy of *Hospital Management*, now becomes a valuable activity of the association, which, under proper direction, will provide a closer and more effective contact with the entire field.

(10) The increasing demands of the hospital field for technical and advisory information—administrative, financial, educational, legal and scientific, convinces me that we should add, as required, more technical and advisory personnel to the headquarters staff.

(11) Affiliation of state and provincial associations with the American Hospital Association is still in a struggling, embryonic state, but I believe the objects of such affiliation could be more mutually, satisfactorily and beneficially accomplished through the addition of a house of delegates or representatives to the present organization, as described in the text.

(12) The hospital field benefiting from the standpoint of economy and efficiency through the various standards developed by the association from time to time, looks to the association to continue to establish such standards, not only in equipment, supplies, organization and procedure, but also in the various services vital to the hospital.

(13) The association can do well to promote better relations and closer contact with all allied organizations in the field, and the federal hospitals of the United States and Canada, as well as hospital interest of foreign countries.

(14) There is a great need for the association to establish and adopt a code of ethics as an antidote to commercialism, unethical publicity, irregular practices and politics in hospitals—all of which in the last analysis affects the patient directly or indirectly, and in this connection I would strongly recommended the adoption of MY PLEDGE AND CREED (as submitted through the courtesy of THE MODERN HOSPITAL) for universal use throughout the hospital field of the United States and Canada.

(15) I believe the time has arrived when the association should have a definite standard of qualifications for membership which carries with it credentials worthy of recognition and confidence.

(16) The urgent and ever increasing need for the training of hospital executives must receive immediate attention and more active cooperation on the part of this association, as well as the organizing of post-graduate refreshing or observation short courses for hospital personnel all over the United States and Canada.

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## GENERAL HOSPITALS OF AUSTRALIA AND NEW ZEALAND\*

By FRANKLIN H. MARTIN, M.D., F.A.C.S., DIRECTOR GENERAL, AMERICAN COLLEGE OF SURGEONS, CHICAGO, ILL.

**A**LTHOUGH the trip which was made in February, March and April of this year to Australia and New Zealand by Dr. W. J. Mayo, of Rochester, Minn., Dr. Richard H. Harte, of Philadelphia, Pa., Dr. Richard R. Smith, of Grand Rapids, Mich., Mr. J. H. Kahler, of Rochester, Minn., and the writer was primarily a vacation pilgrimage, our keen desire to see things medical led us to visit some of the leading hospitals on these island continents of the Pacific. The readers of *THE MODERN HOSPITAL* may be interested in a brief resumé of our impressions.

We visited hospitals in Sydney and Melbourne, Australia; and Auckland, Wellington, Christchurch, Dunedin, and Napier, New Zealand. Almost without exception the general hospitals of these two countries are of the same type. The massive institutional architecture of most of the buildings dates back to the end of the last century. The later additions, as expansion de-

ficial heating was not a problem when the sites were selected, the grounds are ample, and the structures are of the pavilion type, connected by passage-ways which have roofs but are usually otherwise partially or wholly unenclosed. They are supported either by the governments, the states, the municipalities, or in some instances by more than one of these governing authorities.

These institutions are exclusively for the pauper poor, and for those who are able to pay a small fee for hospital care; not unlike the great hospitals of London. The members of the acting or "honorary" staff serve without compensation, nor do they receive fees from the pay patients of these hospitals. As a rule, each hospital is under the supervision of a full-time medical superintendent who looks after all emergency cases and has general charge of the care of the sick. In the larger hospitals, this superintendent has one or more salaried assistants in a pathologist,



Sydney Hospital, Sydney, Australia.



Royal Prince Alfred Hospital, Sydney, Australia.

manded, are of similar architecture, or very often of the conventional style of the period. As arti-

an x-ray specialist, and so on. A training school for nurses, with a competent matron and assistants in charge, is a part of each hospital.

Hospitals of the type described above are not

\*The author acknowledges indebtedness to Dr. Richard R. Smith, Grand Rapids, Mich., for photos used in this article.

the most satisfactory institutions from the standpoint of serving the best interests of all patients—the well-to-do and the poor—and, as well, the best



From top to bottom: Dunedin Hospital, Dunedin, New Zealand; Christchurch Hospital, Christchurch, New Zealand; Auckland Hospital, Auckland, New Zealand; Wellington Hospital, Wellington, New Zealand.

interests of the entire profession. I believe it is the consensus of opinion of medical men of the world, particularly those who travel, that the most commendable system of hospitals is that which prevails in the United States and Canada. The medical profession of Australia and New Zealand are not unmindful of the fact that their institutions for the care of the sick are hampered by traditional drawbacks. They are hopeful of a plan that will obtain the advantages of the new ideas and at the same time preserve all of the advantages of the old, this to be accomplished through evolutionary rather than revolutionary methods and without prohibitive expense.

### Have Well Equipped Laboratories

Most of the general hospitals have a well-equipped laboratory with many of the latest refinements, some including up-to-date metabolic departments. These laboratories have full-time technicians and, in most instances, have a full-time, paid pathologist in charge. The x-ray departments are adequate, a few of them with apparatus for applying deep-ray therapy. The records are well looked after, and in nearly all of the institutions clerks are employed who aid in writing and filing the reports. It is a definite responsibility of the interns to keep these records complete. Separate record findings for the various departments are required by almost all of the hospitals. Staff meetings, where developed at all, are rather in the nature of clinical society meetings than for the purpose of discussing the professional conduct of the hospital. With the exception of the fundamental defects of organization here referred to, the general hospitals of Australia and New Zealand are of the standard type.

### Private Hospitals for the Well-to-do

The outstanding men of the profession, who conscientiously devote their time and skill to the care of the patients of the institutions, comprise the attending staffs of the hospitals. They work without compensation, and with a considerable sacrifice of time. Their private work of a hospital nature is done in private hospitals or "nursing homes." As a result, there is a definite demand for private hospitals in which patients of means may be treated by the doctors of their choice, and in which the patients are privileged to pay for professional services rendered them. For that reason there are many small institutions which bear the name of the doctor who owns the hospital. Some of these private hospitals are reconstructed residences, with a matron (usually a trained nurse) in charge. Obviously these small

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institutions are dependent, to a greater or lesser degree, upon organizations which are less adequate than the general hospitals, especially in regard to laboratories, x-ray service, operating-room equipment, and a regular nursing organization, all of which are abundantly supplied in the general hospitals.

This anomalous state of affairs compels the most competent physicians and surgeons in the two countries to utilize private hospitals, some with inadequate facilities, and thereby places the conscientious man of the profession at a great disadvantage because he is unable without great effort and inconvenience to provide for his patients of means the same facilities as are accorded to the poor in the general hospitals. The people of means themselves are at an even greater disadvantage, as the private hospital is, consequently, a last resort for them instead of the haven of opportunity which is afforded by the hospitals of the United States and Canada.

### Paths Open to These Hospitals

When the profession and the people of Australia and New Zealand become fully aware of the inconsistencies and the difficulties which are the result of this situation, they will do one of two things: either they will allow their general hospitals to degenerate into purely pauper institutions by encouraging the building of more comprehensive private hospitals, or they will do what would be more advantageous—combine with their large and expensive equipments of general hospitals pavilions equipped to care for patients of means, who may then pay not only for their hospital treatment, but also for the professional services which they receive from their physicians or specialists.

A number of the best private hospitals of these two countries are under the control of the Roman Catholic Sisters.\*

### General Hospitals of Australia

The Melbourne Hospital, the largest in that municipality, is centrally located and has a capacity of 400 beds. It is one of the few hospitals with circumscribed grounds visited by us in the two countries. It occupies one city block and is compactly built to cover the entire ground, with no room for expansion except in additional height. However, it is thoroughly equipped and has a large and enthusiastic staff. One of the interesting features of our visit here was our presence at a clinical meeting of the attending honorary staff with the house staff. Several

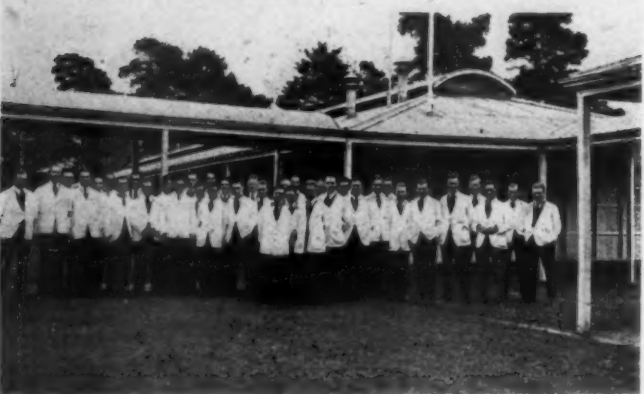
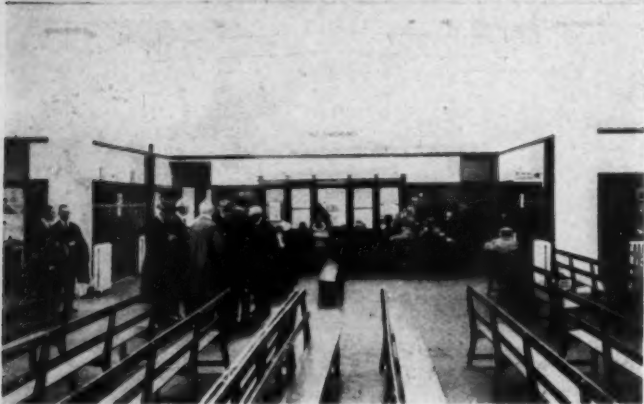
patients were brought in and presented, and an animated discussion ensued. There was a very interesting, spirited, and critical play of words,



From top to bottom: Royal Alexandria Hospital for Children, Sydney; Wards of Royal Alexandria Hospital for Children, Sydney; Another view of the Royal Alexandria Hospital for Children, Sydney; Pathological department, Royal Prince Alfred Hospital, Sydney.

\*A brief resumé of our impressions of those hospitals appeared in the July number of *Hospital Progress*.

give and take, between the internists and the surgeons. The hospital is a university institution where 120 senior medical students receive



From top to bottom: Nurses' home, Alfred Hospital, Melbourne, Australia; Out-patient department, Alfred Hospital; medical students, Alfred Hospital; ward of Sydney Hospital, Sydney.

their clinical instruction. It cares for free patients and those who pay a small fee. No fees are paid to members of the attending or "honorary" staff, who are clinical teachers in the medical school. The well-equipped laboratories are under full-time directors, the x-ray equipment is thoroughly up-to-date, and there is a complete system of records. A large training school for nurses is connected with the institution.

The Alfred Hospital, Melbourne, is one of the most complete and beautiful of all of the hospitals we visited. It covers a large plot of ground and is comprised of two and three-story pavilions which are joined by long covered galleries. Its present capacity is 340 beds, but it is planned for 600 beds. The laboratories and x-ray departments are complete. This is a teaching hospital connected with the medical school, and conducts a training school for nurses with a capacity at present for ninety-two pupils. This institution is under the control of a board of managers, not unlike our own hospitals, and is partially supported by voluntary contributions, with a small grant from the government. Its staff meets once a month and conducts a clinical meeting. It has a fair system of records, and the patients are free and part-pay patients, with no fees to the attending staff.

The Sydney Hospital, located on an elevated site with capacious grounds, is one of the institutions of the University of Sydney. It has a capacity of 350 beds and conducts a nurses' training school which has 130 pupils. The comprehensive records are in charge of a registrar and an assistant registrar. The laboratories of this institution are unusually complete and have a full-time pathologist, bacteriologist, and radiologist. The Sydney Hospital, which commands the best professional talent in Sydney, cares for free patients, and receives a small fee for hospital care from patients who are able to pay. No fees are paid to the attending staff for professional services.

The Royal Prince Alfred Hospital, of Sydney, one of the largest and most complete that we visited in Australia, is a teaching hospital affiliated with the university. This institution, which obviously is well conducted, made a favorable impression upon our group. It is attractively located, and its architectural appearance is satisfactory. It cares for the free patients and patients of moderate means who can pay for a part of the expense of hospital care. There is no provision for patients of means. The training school with its four-year service requirement has 200 pupil nurses. The pathological department is in charge of a competent pathologist, and apparently

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is well equipped. The records appear to be comprehensive, and are cared for by a full-time registrar.

### Royal Alexandra Hospital for Children

The Royal Alexandra Hospital for Children, Sydney, which was one of the most satisfactory special institutions that we had the privilege of visiting on our pilgrimage, is a most complete institution for the care of children. Privately conducted, with the genial founder, Dr. Charles P. B. Clubbe, still acting as president, it is supported by philanthropic contributions, with limited government grants for the care of free patients. The attractive building on the two-story pavilion plan is beautifully located on spacious grounds, with room for expansion. It has a capacity of 340 beds, provides clinical teaching facilities for the university, and has an honorary and exclusive staff, as do all of the general hospitals in Australia. It has an up-to-date dental department, where nurses are instructed to do first-aid work on the teeth of children, and a training school for nurses in which 120 pupils are taking the four-year course of training. The operating rooms, the pathological department, the record department, and the x-ray department all appeared to be thoroughly satisfactory. A full-time mechanic and a shoemaker are employed to make shoes, splints, and other orthopedic apparatus. None but children are treated in this hospital.

### General Hospitals of New Zealand

The Auckland Hospital, one of the largest institutions in the two countries, contains 540 beds. Two hundred nurses are pursuing the course in the nurses' training school. The full-term nursing course is four years, but the students have the privilege of taking a licensing examination at the end of three years. The complete laboratory is in charge of a full-time pathologist. The records are comprehensive and are looked after by the heads of the several departments, the interns, the superintendent, and clerks. The medical superintendent has his home on the hospital grounds. This superintendent, Dr. Charles Evans Maguire, is a trained hospital executive of more than local reputation, full of ideals and obviously thoroughly conscientious. The hospital has several pavilions, including a children's department, and a luxurious home for nurses located on the grounds. The site is in a beautiful part of Auckland and commands a fine view of the city and of the picturesque harbor.

### Attending Staff Receives No Fees

The Wellington Hospital, which houses 320 patients, has a substantial building with several

pavilions. It cares for the poor and other individuals of the country who present themselves. A small hospital fee is asked of those who can afford it. It is not permissible to pay a fee to any member of the attending staff. The honorary staff consists of four medical practitioners, four surgeons, one anesthetist, and one genito-urinary specialist. There is a separate state maternity hospital.

The Wellington Hospital has a part-time radiologist, and a part-time pathologist, each of whom have paid technicians. The house staff consists of a full-time medical man who does some clinical work but who cannot receive fees, and a superintendent who has jurisdiction over an assistant superintendent and six house interns. The interns receive, besides their housing and board, £200 a year. The training school, which has a course of four years, is in charge of a matron who is a trained nurse. Automatically the graduates are licensed to practice anywhere in New Zealand. The bacteriologist of the hospital is a full-time official, and does work for practitioners of the country. He has six assistants. Records are well kept and take into consideration the work of all departments. There are get-together meetings of the house staff, but staff meetings of the type required by our minimum standard are not developed.

The Christchurch Hospital, with a 300 bed capacity, has several fine permanent buildings. An honorary staff is organized and the doctors are not permitted to receive fees. Either no fee, or a very small fee, is asked for hospital service. The well-equipped laboratory is under the supervision of a full-time director. The x-ray department is up-to-date, the operating rooms are thoroughly well equipped, and the records are kept by the interns. There are staff meetings, but not for the specific purpose of reviewing the professional conduct of the hospital. One hundred and twenty nurses are pursuing the three-year course of training. Dr. Fox, the chief, was our host on the occasion of our visit to Christchurch Hospital.

The Dunedin Hospital is virtually a part of the medical department of the Dunedin University. Its buildings are attractive and consist of several units which have a capacity of 300 beds. Dr. Falconer, the medical superintendent, is enthusiastic about his work, and was careful to explain in detail the conduct of his institution. There are eight house officers or interns who receive, in addition to maintenance, £100 the first year, and £150 the second year.

The training school has seventy pupil nurses.

(Continued on page 406)

# THE ORGANIZATION OF A PHYSIOTHERAPY CLINIC IN A GENERAL HOSPITAL\*

By F. B. GRANGER, M.D., BOSTON CITY HOSPITAL, BOSTON, MASS.

**T**HE World War, among other things, gave birth to physiotherapy. Not the physiotherapy which had previously existed, with each branch operating independently, but a physiotherapy in which the separate units coordinated as a whole. It also served to emphasize the fact that physiotherapy should exist as an adjunct to all other medical and surgical measures. It was this team work which so successfully put over the whole program in the army.

The lessons learned there are applicable, with some modification, not only to the disabilities of our industrial army, but also to many phases of disease and convalescence. Functional restoration is the key-note of its rationale.

In this series of articles I shall discuss the personnel, equipment, floor space required and its arrangement, the relation of a physiotherapeutic clinic to the other clinics of the hospital, types of cases usually referred, record system, progress of a case through the department, and a brief summary of the end results.

## A Definition of Physiotherapy

There have been many definitions of physiotherapy, but, to my mind, the best is that given by the Surgeon General of the United States Army, when in creating the department of physical reconstruction he defined physiotherapy as:

"All measures which are conducive to cure such as are comprised under the term physiotherapy, which includes hydrotherapy, electrotherapy, and mechanotherapy, active exercise in the form of games and passive exercise in the form of massage."

As a consequence of this, the department of physiotherapy was divided into five sections, all under one head, and coordinated perfectly with each other. These sections were: for hydrotherapy, for massage, for electrotherapy, for reeducational exercise (muscle training) and for mechanotherapy.

The following is based on the treatment of 125 daily cases. Though at first glance this may seem excessive, yet in practice, when once the idea of physiotherapy with its functional restoration has been sold to the staff, its natural desire to attain the best possible results will impel it to send for treatment many cases which hitherto would not have been considered suitable.

The personnel based upon 125 daily cases consists of: one physician in charge, one or two assistant physicians, two male aides or technicians, one of whom must be skilled in hydrotherapy, one chief aide (preferably a woman), six female aides, one of whom must have a knowledge

of hydrotherapy, two or three voluntary assistants, one record clerk, and one orderly.

It is absolutely essential that the physician-in-charge should have had adequate training in physiotherapy, for upon his knowledge depends the success of the department.

The assistant physicians should also have some knowledge of this special branch. They should be preferably young men possessing the necessary enthusiasm and push to carry out the work and to conduct the scientific research which is sorely needed if physiotherapy is to be placed on a sound basis.

During the war a wonderful body of intelligent young women were trained to carry on this work.

## Physiotherapy's Place

**S**INCE the World War physiotherapy is taking its place along with the other departments of the general hospital. Its value as an adjunct to all other medical and surgical measures is gradually being recognized by hospitals which are establishing departments of physiotherapy. The organization of these departments entails difficulties in the way of securing the necessary trained personnel and adequate, up-to-date equipment.

At present only two medical schools give post-graduate courses in physiotherapy, but in some medical centers there is a movement on foot to encourage the training of aides. Dr. Granger, who has made a thorough study of the problem, outlines here the essentials of a physiotherapy clinic in a general hospital on the basis of 125 daily cases.

\*This is the first of a series of three articles on the subject of physiotherapy, prepared for THE MODERN HOSPITAL by Dr. Granger.

Some of these army aides are still available as head aides. If possible, such a one should be selected to head the work, as not only executive but also technical ability is required. The other aides should be chosen for their general, all-around knowledge, though the greatest emphasis should be placed on their ability in massage, analysis of muscle movement, and their proficiency in muscle training.

The mechanical part of electrotherapy can be imparted by a competent head aide with the assistance of the physicians of the staff.

### Plan Courses for Normal Schools

At some medical centers a movement is on foot to give graduates of normal schools of physical education a post-graduate course in physiotherapy. If this program goes through, an adequate supply of well-trained aides will be assured. The aides' wages vary with existing conditions. The United States Government pays such workers from \$1,620 to \$2,500 a year, without maintenance. At the Boston City Hospital, because of the fact that there are a number of well-trained former army aides who do not desire to leave home, the following wage scale is in force:—aides—\$28 a week; assistant head aide—\$30 a week; head aide—\$35 a week with two weeks vacation and thirty days' sick leave with pay.

These aides must pass a civil service examination. They work forty-four hours a week, the department being closed on Saturday afternoons. We also have some well-trained aides on part-time duty. They work every morning from nine to twelve-thirty, and are paid \$14 a week. This arrangement assures them of a steady income in addition to the amount they receive from their private work. It also secures for the hospital an augmented corps of workers when the outpatients are being treated. (Ordinarily the house cases are treated in the afternoon.)

### Results of Treatment Studied

An attempt is made to train the aides to watch carefully the results of treatment, the patient's reaction, improvement and non-improvement. Anything out of the ordinary is to be reported immediately. Once a week a conference is held and the needs of the department are discussed. The aides are encouraged to ask questions, particularly as to why a certain treatment was prescribed, also to make suggestions in regard to improvement of technique or change of treatment. We are trying to get away from the grind of routine work and not fall into the error of certain insurance clinics where physiotherapy has degenerated into—"bake and rub." An orderly is

necessary not only to transport patients to and from the wards, but also to keep the clinic picked up. At present, for the training of physicians, there are only two medical schools giving post-graduate instruction in physiotherapy—Harvard and the University of Pennsylvania.

The equipment based on 125 patients daily, with segregation of the sexes, is outlined in the following paragraphs.

In ordering any electrical equipment great care should be taken to specify the type of current used. If a hospital has its own power plant ordinarily the 110 or 220 volt direct current is available. If the current is bought from a power company, the 110 volt, 60 cycle, alternating current is generally supplied. Some pieces of electrical apparatus such as bakers, deep therapy lights, small vibrators, small motors and the like can run on either current, while, on the contrary, the high frequency requires the alternating, and the galvanic and sinusoidal require the direct current. If both types of current are not available from the current mains, it is necessary to have a piece of apparatus to change one type to the other. These are called rotary converters when the direct current is changed to alternating (high frequency) and motor generators when the alternating current is changed to the direct (galvanic.)

Frequently these are furnished by the electrical manufacturers with each individual piece of apparatus. This is not only more expensive as to first cost, but the up-keep is higher. A small rotary or motor generator is generally overloaded, and will thus heat rapidly with consequent loss of current and not infrequently, damage to the machine, as the heat may be sufficient to melt the solder which is used to secure the electrical connections. Therefore it is better to figure the current demand and install one or two rotaries or converters large enough to take care of all the machines running at maximum load. This entails extra wiring, but the consequent lowering of up-keep and the avoidance of delays in treatment due to damaged small rotaries, converts the extra expenditure into a profit rather than a loss.

Also if such large rotaries or generators are installed outside of the department, the noise which they make will be eliminated, thereby sparing the nerves of patients and technicians. It is also well, though this will be considered under the arrangement of floor space, to have a number of separate branch lines running off from the large panel box where the main line comes in. In this way should a machine short circuit and blow a fuse, only that particular branch would probably be out of commission and the general work

would be uninterrupted. Also it is well to have the plugs and receptacles of the A. C. and D. C. so different that it is impossible to plug a D. C. machine on an A. C. circuit or vice-versa.

The electrical apparatus needed includes:

(1) two large high frequency coils capable of delivering a heavy current for autocondensation and electrocoagulation (cost around \$700); (2) seven small portable high frequency coils for diathermy (one to be mounted on a movable table with large casters for occasional use in the ward, cost around \$250); (3) four galvanic sinusoidal machines (cost—\$400 each); (4) three Bristow faradic coils (cost—\$50 each); (5) one galvanofaradic for nerve testing (cost \$70 to \$75); (6) six galvanic controllers with meters and preferably equipped with a pole changer (cost \$50 to \$55 each); (7) two electric vibrators; (8) two 1000 watt, deep therapy lights mounted on a movable stand (cost \$100 to \$125 each); (9) eight portable light applicators (for radiant heat baking); these should contain from six to eight incandescent light bulbs (cost—\$43 each); (10) two ultraviolet air cooled lights (mercury arc type cost \$350 to \$400 each); (11) one ultraviolet water cooled type light (mercury arc type cost—\$400).

The following equipment is not absolutely essential but at times very useful: one static machine having sixteen revolving plates with insulated platform and accessories (cost \$1,600), and a Morse wave generator (cost \$375 to \$400.)

## GENERAL HOSPITALS OF AUSTRALIA AND NEW ZEALAND

(Continued from page 403)

A three-year course is required for graduation, but those who desire advanced training may take a graduate course of one year. Each nurse receives £10 for her outfit, and in addition £30 for the first year, £40 for the second year, £50 the third year, and £60 the fourth year. The records are not too comprehensive, but include bedside notes, pathological findings, and the blood and urine records, which are worked up by the interns. The laboratory is in the medical school. The x-ray equipment is of the conventional type and is located in the hospital building. The operating rooms are well equipped and up-to-date.

### Hospitals Have Honorary Staffs

The Napier Hospital is beautifully situated on a bluff overlooking the city and the sea, and has a capacity of 250 beds. It has a training school for sixty nurses, with a three-year course. This hospital is conducted on the plan of the other New Zealand institutions, with an honorary staff,

free and part-pay patients, but no fees to physicians. The hospital site is capacious and several separate pavilions accommodate the different departments.

### A VALUABLE DESK DIRECTORY

Early in the new year, if not sooner, the fifth edition of THE MODERN HOSPITAL Year Book will be issued and will undoubtedly prove as valuable a desk directory as have the earlier editions, besides serving several other much needed and useful purposes for hospital executives.

The book will have a "finding list" through which it will be easy for the busy hospital man to locate in a moment the manufacturer or distributor of any needed device or apparatus. It will be a guide to intelligent purchasing of routine supplies and equipment. Detailed descriptions and specifications are given of the varied items used in hospital construction and maintenance.

The following are some of the subjects treated in the editorial sections of the volume: Budget control, a subject discussed in last year's edition and now approached from a new angle; the equipment of laundries in small hospitals, showing how a hospital with an average monthly laundry bill of \$250 can save \$100 a month, kitchen equipment and supplies, how space may be saved when planning the kitchen, what should be included in the initial installations, and foods and beverages discussed in a manner of interest to dietitians.

### GRADUATE SCHOLARSHIP AWARDED TO ORANGE, N. J., NURSE

A scholarship in graduate nursing has been awarded by The *Trained Nurse and Hospital Review*, New York, N. Y., to Miss Maud Gegenheimer, a graduate from the Orange Memorial Hospital, Orange, N. J. This scholarship permits the winner to pursue post-graduate work at any accredited school of nursing. Miss Gegenheimer is planning to take a course in nursing administration at Teachers' College, Columbia University, New York, N. Y. She is a graduate from the West Orange High School. Both prior and since her graduation, from the training school of the Orange Memorial Hospital, she has been teaching practical nursing at that hospital.

Miss Mildred Fischer, a graduate from the New Madison Hospital, New Madison, S. D., and Miss Josephine Smith, a graduate from the Methodist Episcopal Hospital School of Nurses, Indianapolis, Ind., were close contestants for this scholarship award. The remarkable records of each of these nurses, in school, before the state registration boards and in subsequent positions of trust, entitle them to recognition.

When the scholarship competition closed on July 31, 1924, over 100 theses had been submitted and, after having been carefully considered by the editor, including the recommendations of the superintendents and the attested state board averages, the papers of the ten leading competitors were submitted to the scholarship committee and the award was made to Miss Maud Gegenheimer who will receive the \$200.00 which this scholarship carries.

The American Medical Association has instituted a new service in the form of the package library which will supply, for very slight charge, materials from foreign languages, recent reprints and materials covering highly specialized topics. The package libraries will be sent out from the headquarters, Chicago, Ill.

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## THE MARY McCLELLAN HOSPITAL, CAMBRIDGE, N. Y. A SELF-CONTAINED MODERN INSTITUTION

By M. M. SUTHERLAND, R. N., SUPERINTENDENT, MARY McCLELLAN HOSPITAL, CAMBRIDGE, N. Y.

THE Mary McClellan Hospital, a modern and complete, self-contained institution for the care of medical, surgical and obstetrical cases, was erected at Cambridge, N. Y., through the generosity of one of its citizens, Edwin McClellan, on a park-like knoll embracing eighty-four acres just west of the Washington County village, in one of the most attractive locations in the beautiful Cambridge Valley.

The site is splendidly chosen on a partially wooded knoll, rising gradually several hundred feet out of the western part of the Cambridge Valley, famous as a rich seed, dairy and farming country, and from it in all directions are broad views of valleys and hills, with mountains in the distance. The view extends to the northeast even to Mount Equinox in Vermont and the lake region between Shushan and Salem.

The hospital site is at the western end of the village of Cambridge, about a mile from the sta-

being reached from Main Street through Myrtle Avenue, and another road leading from the highway to the south. Some 85,000 evergreen trees were set out on the property, principally white pine, with spruce on the low ground and Scotch pine on the knolls. Its attractive surroundings will be further beautified with park-like effects.

### A Hospital Entirely Self-Contained

Aside from the location, the feature of the hospital which makes it almost unique is that it is an entirely self-contained institution with its own electric lighting, heating, water and sewage disposal plants, almost sufficient in capacity for a small village. The work of construction was made difficult by the fact that just beneath the top-soil the entire knoll is solid rock. But this makes for the solidity and permanence of the buildings erected thereon, for all the foundations are well imbedded in the rock, as well as the pipe lines



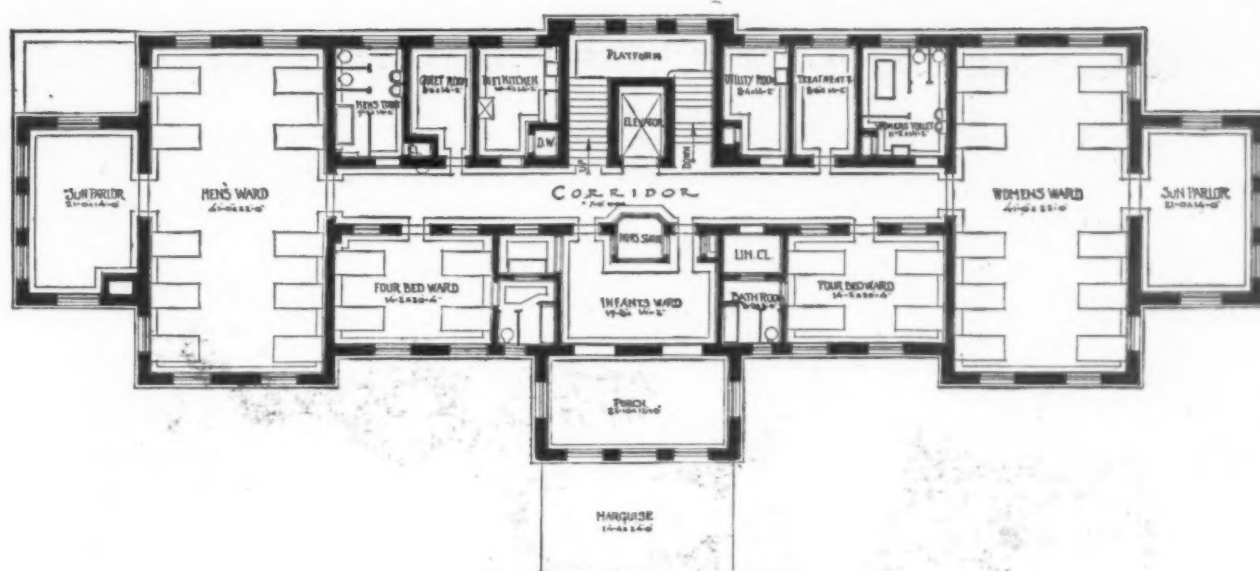
The Mary McClellan Hospital, Cambridge, N. Y. The medical director's home and the junior building are seen in the background to the right.

tion. In order to make it available it was necessary to construct roads to the summit. For this purpose more than a mile of broad highways at easy grades have been built, the main entrance

extended to all the buildings, and the storage reservoir of concrete built in the hill-top about 130 feet higher than the main building.

The institution consists of eight buildings in-



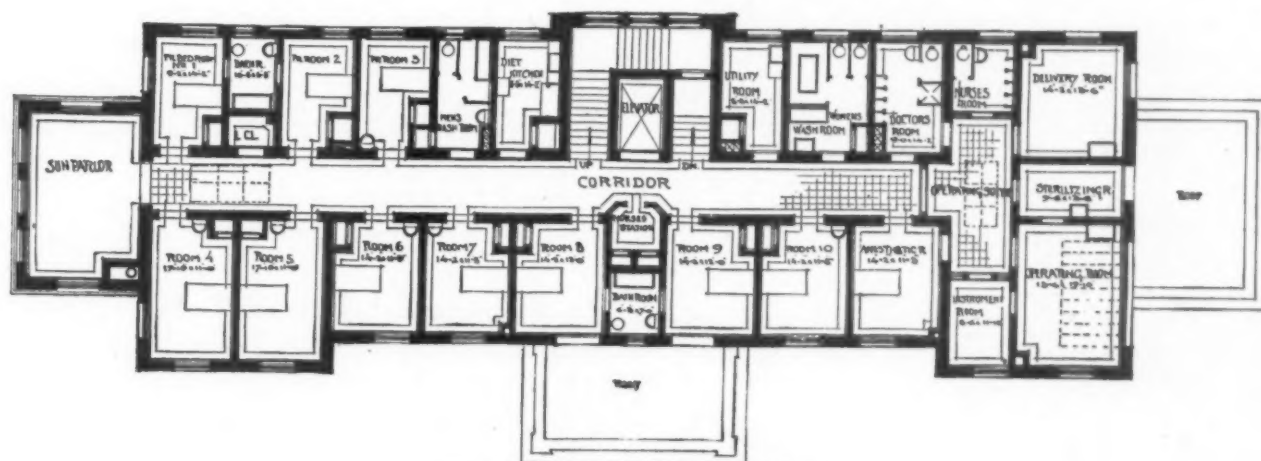


Plan of first or ward patients' floor.

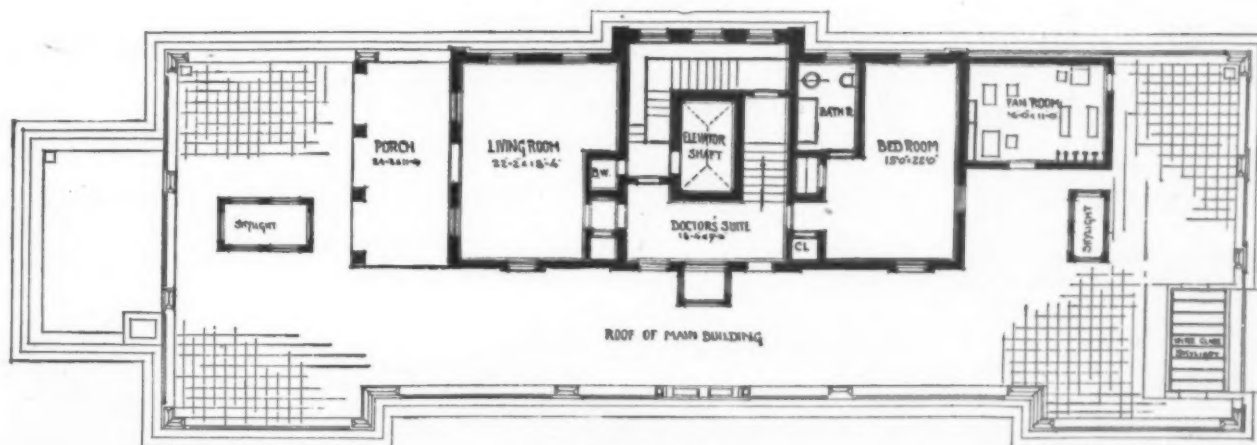
screened in. From the porch the entrance is into the reception hall on the ground floor, with a floor of pink Tennessee marble blocks. Through the center length of the building on each floor extends a corridor. At the right of the reception hall is the office and directly opposite the entrance hall is an electric elevator to the floors. Along the rear of the corridor are the laboratory, medical supply

room, x-ray and dark rooms, and toilet and washroom.

At the left of the main entrance is the service portion of the building, cut off by solid partitions and confined to the ground floor. This portion includes the nurses' dining room, serving pantry, dining room, kitchen, etc., with tile floor throughout and up-to-date sanitary devices and equip-



Plan of second or private patients' floor.



Plan of third floor.

ment. In the basement are storage rooms, drug room, linen room, and autopsy room.

On the first and second floors opposite the elevator is a nurses' booth, or kiosk, so located that

of metal and the only wood used in the building is in the doors, window frames and sash. Sanitary drinking fountains are installed on each floor. The hospital has a capacity of fifty patients.



Nurses' home, Mary McClellan Hospital.

full view is given of the entrances and corridors. On the first floor at the north end of the corridor is the women's ward and at the south end the men's ward, to each of which is attached a sun parlor. There are two four-bed wards in front, with the infants' ward in the front center opening onto the screened-in porch. Separate bathrooms are provided for each ward. On either side of the elevator shaft are a diet kitchen and utility room, a quiet room and a treatment room, linen closets, etc.

On the second floor at the north end is the operating suite, with operating and delivery rooms and a sterilizing room in between, also the etherizing and instrument rooms, and separate wash-rooms for the surgeons and nurses. The arrangement of these makes for efficiency. There are also on this floor ten private rooms, two provided with private baths and two general baths, and toilets, and the usual diet kitchen, utility room and linen closets. The two central front rooms open on the balcony over the entrance porch.

On the roof is the house physician's quarters, consisting of bedroom, living room, bath and porch, also the fan room which controls the ventilation. Iron girders support the concrete floors, which are covered with tile and battleship linoleum with terrazzo base. The walls are finished with plaster, except in the kitchen, bathrooms and operating rooms, where glazed tile is used. The door trim is

The power house, which is two stories high, forty-seven by sixty feet in dimensions, is of brick with bluestone trimmings, and is located about seventy-five feet to the rear of the main building, with which it is connected by an underground concrete corridor. The power house is equipped with two large boilers and three electric generators. Above the power house are four sleeping rooms and bath and a spacious laundry.

### Three-Story Nurses' Home

The nurses' residence is a three-story and basement building providing accommodations for forty nurses in separate rooms with baths, lavatories, and showers on each floor. Rooms with baths are provided for heads of departments, and rooms for night nurses on the third floor are shut off from the main corridor so that they may be undisturbed. A reception hall, library, living room and sun parlor are provided on the first floor and there is a wide veranda at the east end. The basement which is almost wholly above ground provides class and demonstration rooms, kitchenette and small laundry for the use of nurses, and a trunk room. There is one centrally located fireproof stairway, and suitable fire escapes at either end.

An ice-house with cold storage, fifty-five by thirty-five feet in dimensions, was erected west of the hospital and a large root-cellar south of the

main building where it is of easy access.

The water supply comes from two wells on the property, the first 590 feet deep, the second 202 feet deep, located about 500 feet west of the hospital. The water is forced by air pressure to a double concrete reservoir on the hilltop, 130 feet above the hospital, from which it flows through the service pipes by gravity. The reservoir has a capacity of 125,000 gallons. In addition to this connections have been made with the village water supply giving an auxiliary service of water in cases of need.

### Nurses' Training School

With the opening of the college term, September 21, 1922, the Mary McClellan Hospital at Cambridge, N. Y., brought to this section of the country an opportunity for the college training of the student in nursing. Through an affiliation with the Skidmore College at Saratoga, N. Y., the following course, covering five years, has been apportioned as promoting the best results:

First Year—Nine months from mid-September to mid-June to be spent at Skidmore College.

Second Year—The next three months, from mid-June to mid-September, to be spent in the hospital in intensive class room training in hospital principles, theory and practice.

Third Year—The next nine months, from mid-September to mid-June, to be spent at Skidmore College.

Fourth Year—The next twenty-four months, two full years, to be spent at the hospital.

Fifth Year—The final term of nine months, from mid-September to mid-June, to be spent at Skidmore complet-

qualify to continue nursing, this probationary period will afford excellent opportunity for laboratory work in connection with the first year's college work and a keener appreciation of the next nine months' college course.

During the final year of hospital training, preparatory to the senior college year, the student will be transferred, without extra expense to her, to one of the institutions of nursing in New York City for affiliation in such subjects as pediatrics, mental and contagious diseases. At the conclusion of her fifth year when the student has received her college degree and her hospital diploma she will have a fully rounded out, scientific, liberal and thorough preparation for her career.

### Health Requirements for Entrance

Every candidate for admission to the Mary McClellan Hospital School of Nursing must also make application to Skidmore College upon the blank form furnished by the college, and must submit before entrance a statement of honorable dismissal from the institution last attended, together with a certificate of health. Any bearer of the new college entrance diploma of the Regents of the State of New York will be received into full membership in the freshman class without condition. For all other persons satisfactory completion of a four-year course of study in an approved high school, including certain definite prescriptions which are explained fully in the bulletin of the college, or clear evidence of equivalent



Scene showing the location of the Mary McClellan Hospital. The home of the medical director is seen in the foreground and the junior building in the background.

ing work for the bachelor of science degree. At the end of this time the hospital will give the diploma.

The three months which are to be spent in the hospital following the first nine months of college training will correspond to the probationary period in other training schools. To students who

education, is required for entrance.

The age of admission to the hospital training school will be from seventeen to thirty-five years. To the girl fresh from high school the minimum age offers a distinct advantage in that it takes her direct from the high school into the college

and utilizes the intervening years between graduation and admission to the hospital. Before entering Skidmore the applicant must submit a certificate of health from her physician which will be satisfactory to Skidmore and to the hospital. This record will be supplemented by a physical examination by the director of the school of health and physical education.

### Rural Service of the Hospital

The Mary McClellan Hospital represents a most noteworthy attempt to furnish medical and surgical service of a high standard to rural communities. No expense has been spared on the part of the founder to attain this object.

The problem of the relationship between the hospital staff and the local physician—always a delicate and difficult one—was made unusually so in this case by the somewhat unique method of organization. Every effort was made by the board of trustees, as well as the hospital staff, to further the spirit of cordial cooperation on the part of the local and county men and to make them feel that the chief object of the hospital was to help them render better service to their patients, by placing at their immediate command all the facilities of well-equipped laboratories together with a regular opportunity for consultation. In other words, the hospital as developed furnishes on a small scale a true diagnostic clinic for a rural community.

The resident staff consists of two men both of whom have had a thorough medical and surgical training in the leading hospitals of New York and Boston. These residents are responsible to the attending staff for the conduct of the medical and surgical work; they have charge of all patients and are at the services of non-staff physicians both for consultation and supervision relating to their patients in the hospital. The residents are on full-time salary and are not allowed to practice outside of the hospital, their responsibility being definitely limited to the foregoing work. They are, however, permitted to go outside in consultation with local practicing physicians.

The director of the x-ray department makes weekly visits for diagnosis and consultation, the detail work of the department being done by a full time technician. The laboratory is in charge of a full-time technician, the chief resident surgeon being the head of the department. The laboratory furnishes free laboratory examination for any physicians in the county as well as for all the hospital patients.

Surgeons in good standing who have been voted the privilege by the board of trustees may per-

form operations on their private patients. Any physician in good standing may treat his private patients in the semi-private and private rooms as well as in the obstetrical and contagious wards, patients making their own arrangements as to fees for medical service with their physician.

### The Hospital's Public Health Work

The hospital from the beginning has been greatly interested in public health questions and, at the present time, is initiating a public health movement with special regard to the children of the immediate communities.

In a recent survey of Washington County made by the service bureau of the American Hospital Association, the following general facts were mentioned which give a good idea of the character of the community work done by the hospital. Washington County with an area of 700 square miles has a population of 45,000 and is 90 per cent agricultural. According to the federal census of 1920 there were 557 children under seven years of age and 5300 between the ages of seven and thirteen years of age, all residing in Washington County. Of these last named 5048 (95.2 per cent) were attending school. As the majority of health work for school children was said to be needed for these two groups, amounting approximately to 11,000 children, these figures give an idea of the child problem in which the hospital is interested. With no planned health work for children of pre-school age, and with limited follow-up of school children following medical inspection, it is apparent that the question of health in children offers a wide field for education, preventive medicine and further medical supervision.

Two clinics have been established to meet the need shown above, the first one being a "well-baby" clinic to which the mothers of all children born in the hospital are invited to bring their babies for monthly inspection and advice. This clinic is working out well and is appreciated by the mothers.

To the second clinic all children of two years and over are invited to come once a month. A thorough examination is given, laboratory tests made where needed, and where necessary a general consultation of all physicians present will be held. The local physicians are invited to assist in this work. The patients will then be referred to the family physician with the information acquired, to help him keep the child well and guide him to a strong and healthy development. There will be no charge made for these examinations and, unless the parent and

(Continued on Page 416)

## THE HOSPITALS AND THE WORKMEN'S COMPENSATION LAWS\*

BY JOHN A LAPP, LL.D., DIRECTOR, DEPARTMENT OF SOCIAL ACTION, NATIONAL CATHOLIC WELFARE COUNCIL, CHICAGO, ILL.

THERE are two phases of the workmen's compensation laws, each of prime importance to the hospitals. First there is the liability of the hospital for injuries to its own employees, and second, there is the relation of the hospital to the care of injured workers who are brought to it for treatment.

On the first proposition, the liability of the hospital for injuries to its own employees, there are several questions.

First, does the law expressly include or exclude hospitals in its operation? The legislature may, in the absence of constitutional restrictions, do as it pleases with respect to the liability of hospitals, whether under compensation laws or otherwise. If it includes hospitals in the operation of the workmen's compensation laws, then they are subject to all the provisions of the act. The legislature may exclude hospitals and especially charitable or public hospitals from the operation of the liability laws.

Some states include only businesses conducted for pecuniary profit. This again raises the question, when is a hospital charitable? The present statutes in the different states on workmen's compensation vary a good deal, and the facts of inclusion or exclusion for each state cannot be set forth here. The second question concerns the definition of what constitutes an employee relationship in a hospital. With the regular manual worker and other workers, no question arises, for they are like employees of any industrial or commercial concern. In the professional staff, however, there is a different relationship, and there are many legal questions which are not yet settled.

Numerous court decisions do not, for example, give the staff physicians the relation of employees. A physician on the staff in a hospital is not an employee of the hospital, but holds an independent professional relation. He, not the hospital, is liable for his acts, and by reverse reasoning the hospital would not be liable for injuries which he, himself, might suffer in the course of his occupation. So far, the question is fairly

clear, but the paid staff of the hospital and the interns hold a different relation. They are employees of the hospital when acting under the direction of the hospital managers, but they also hold a quasi-professional relationship, and in addition, they have a special relation to the physician or surgeon whom they may be assisting. Here is a field of complicated legal and professional brushwood which has not yet been penetrated. The rulings of the commissions and the decisions of the courts have not yet dealt, so far as I am aware, with these questions.

Whose, for example, would be the responsibility

### Hospital Liability

HOSPITALS are affected by the workmen's compensation laws because they are liable for injuries to employees and because they care for injured workers who are brought to them. From the operation of these laws arise complexities with respect to the relation of certain personnel as nurses and interns to the hospital and to those under whom they are directly working.

These relationships constitute a field of complicated legal matter which has not yet been penetrated by the courts.

The hospital is also directly affected in caring for injured workmen. The questions of what constitutes adequate medical care, the basis of payment for hospital service and others which arise call for clear definition.

ity for an accident to an intern assisting a surgeon in the performance of an operation? Probably the hospital would be responsible, but on the other hand, the intern, when assisting a surgeon, is subject to the direction of the surgeon. The nursing staff's relationships present similar difficulties. The nurse works for the hospital, but she also carries out the directions of physicians and surgeons who are not the managers or employees of the hospital. If a nurse were injured while carrying out the directions of her professional superior, the doctor, would the hospital be liable? Probably so, and yet in the given case, the doctor might give the direction which caused the injury. Then again, what is the relationship between the other professional workers, such as x-ray opera-

\*Paper read before the opening general session of the twenty-sixth annual conference of the American Hospital Association, October 7, 1924.

tors and pharmacists, employed by the hospital management itself? Are they employees in the strict sense when they carry on their work on their own independent judgment, and are not subject to direction in their professional capacity by their employers? These are questions which may have been answered by rulings of commissions here and there, but which have not yet reached the stage of formal definition in statutes or in court decisions.

Lastly, the question, what constitutes injury in a hospital, is far more complicated than in many other employments. Pure accidents are similar to those in other employments, but the greatest risk which workers run in hospitals is infection from patients of whom they take care. Is it an accident when a nurse contracts a disease from a patient? It has been held so where the case is clear as, for example, in blood poisoning, but is it an accident when the attendant acquires tuberculosis in a sanitarium? Even where the laws cover occupational diseases, there are uncharted roads to justice for the worker. As a matter of fact, the inclusion of occupational diseases under the workmen's compensation laws of several states is more important to the hospital than the original provisions concerning pure accidents. Just what the final effects of such legislation will be upon the hospital cannot be foreseen, but since every employee of a hospital runs the risk daily of some sort of an infection, it is certain that the hospital should be a factor in shaping occupational disease compensation laws.

Multitudes of questions must come in the next few years before commissions and courts in the attempt to clarify the great variety of technical and professional questions that are latent in the greater peculiarity of relationship between employer and employee in hospitals than in other employments.

### Two Benefits to Injured Workers

In the second phase of this paper we are concerned with the hospital as an agency in administering the compensation laws for the benefit of the employees in the community. The laws provide two benefits to injured workers: cash payment and medical care and rehabilitation. We are concerned only with the latter phase in this paper, but in passing it should be remarked that the low scale of cash payments and the long waiting periods do not give full justice to the workers under the laws of many of our states. That phase of the compensation laws which provides for medical care should receive the earnest thought and planning of hospital managers. It has not had the attention that it deserves in that quarter

in the past. The laws have just grown up. Medical men scarcely gave attention to their provisions.

A search of the New York state medical journals indicates no interest whatever on the part of the medical profession during the many years when the New York State Compensation Law was being framed and enacted. The same could be said of hospital journals. In only two or three states have hospital leaders seemed to realize that this legislation concerned hospitals. Some of the laws are by trial and error reaching toward adequacy of medical care, but no law has yet made clear the relationship which the hospitals should properly sustain to this great social movement, nor have they properly clarified the responsibility of industry and the community to the hospitals for the service which they are called upon to perform under the compensation acts, nor have the laws truly conceived or reflected the fundamental rights of these great charitable institutions. The first minimum standard in workmen's compensation laws should be the adequacy of medical service. The merest tyro in social welfare or in business should conclude from existing evidence that the best way to limit or lessen liability for injuries is to provide good medical care for the injured person. Inadequate or inferior medical care is the most expensive course to pursue, both for business and for society. Consider only the prolongation of disability by poor medical care resulting in infections, or consider the financial loss from bungling care of a fracture, resulting in months or years of disability as against a few days or a few weeks.

### Justice Calls for Rehabilitation

Yet in spite of the obvious social and business economy of the scheme, the first laws provided, and even yet the laws of a majority of the state provide that medical, hospital and nursing care to be furnished as compensation should be limited to a brief time and to an absurdly low amount. To say that the worker shall receive medical, surgical, hospital and nursing care for a period not exceeding two weeks and in no case to exceed \$75 in costs is to nullify the medical service in all serious cases. Many of the existing laws make even more absurd limitations than that, but thanks to a keener social and business insight, several of the leading states have removed all limitations on the expense for physical restoration. Several of the newer laws have gone further and have provided not only for the fullest physical care, but also for the vocational rehabilitation of the injured workers. The Industrial Rehabilitation Act of the U. S. in cooperation with state governments, has given tremendous impetus to industrial compensation

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commissions to carry through real programs which will restore the workers as nearly as possible to their former state of efficiency. Fundamentally, justice to the injured worker and to society calls for the restoration of the worker, physically and vocationally, as nearly as may be possible to his former state, and for compensation for that which cannot be restored.

One of the matters that has been overlooked by the hospitals in connection with the compensation laws is that in the regime of limited medical service it is the hospital which suffers most of the economic losses. The slight injuries can be cared for adequately within the limitations of the statutes, but every serious case which goes to a hospital runs the bill beyond the limit and the hospital is left to carry the load of charity. A patient brought to a hospital and paid for under the compensation laws for two weeks cannot be removed arbitrarily at the end of that time. Unless the patient or his friends take him somewhere else the hospital must continue to take care of him.

In the main the worker, under such circumstances, is thrown upon the charity of the hospital. The question naturally arises here, why should the hospital be called upon to assume this expense? The law fixes the liability for compensation upon the employers who generally insure against their liability in an insurance company. The compensation laws were passed as a compromise between employers and employees. The employee gives up the right to sue for indefinite amounts of damages, and the employer assumes a fixed scale of payments for injuries in return for freedom from excessive liability. The worker acquired rights in this arrangement, chief of which includes responsibility of employer or the insurance carrier for his medical care.

### Hospital Should Not Bear Cost

Obviously the cost should not be borne by the hospital nor should any portion of it be shunted upon it. When the responsibility rests upon employers and insurance carriers, the hospitals, by assuming any portion of the cost of caring for injured workers, are giving their charity not to the injured worker, but to the employer or the insurance company. All that is needed is a little straight thinking on this point to bring it clearly within the understanding of everyone concerned. The hospital has no moral right to use the charitable funds which it administers in assuming the express burdens of employers or insurance companies, and in order that they shall not thus use their funds, accurate accounting should be provided so that every dollar of expense which charitable institutions are bearing under the compen-

sation laws shall be paid for from the proper sources. This accounting should provide, in determining the expense of care, for interest on hospital investments and for depreciation, as well as for actual current per capita cost incurred in the care of the patient.

Another matter to be considered is the determination of what constitutes adequacy of medical care for injured workers. The laws of most of the states provide that such medical care shall be the equivalent of that which is generally provided in the community under similar circumstances. Does this mean that injured workers shall be provided the minimum accommodation of the hospital, the medium or the maximum service? Or does it mean that a workman who would probably have the cheapest ward accommodation if he were to go to the hospital otherwise than through an injury, shall have the cheapest ward accommodation, and that another person who probably would have had accommodations in a small ward shall have like accommodations under the compensation laws and that, further, the better-to-do worker who would perhaps have a private room would have such room at his disposal if he went to a hospital through an accident under the compensation law?

### Gravity of Case Should Govern Care

It is apparent that in the main the injured workers get the minimum of hospital accommodations, yet in all reason their treatment should be primarily dependent upon the gravity of the case rather than upon their economic status. If a private room is necessary for the proper care of the poorest worker a private room should be provided. If a high-priced, expert medical service is needed to save or restore a human being it should be provided regardless of expense, with the condition only that all charges must, of course, be reasonable. We shall need to go far before there is general recognition that injured workers are not charity patients.

The above principle does not require unreasonable attempts to get the best medical and hospital service; it does not require that patients be taken to the best special hospitals only or that specialists be brought from the ends of the country. It does require that the best that is available in the community, if needed, shall be supplied. An injured worker is not entitled to the regular services of a high-priced specialist if a general practitioner will do; he is not entitled to the best hospital rooms when semi-private wards or even general wards will serve him properly. But the patient is not an object of charity and he should know that he is not.

Another question will not be downed in the discussion of workmen's compensation; that is, the right of the patient to choose his physicians and, within limitations, the hospital to which he is to be sent. Most of the states put the duty on the employer to provide medical care and the injured employee is subject to the orders in this respect of his employer. He may refuse to be treated by his employer's physician or in the hospital of his employer's selection, but if he does he must pay the bill himself. Now it ought to be axiomatic that the employee should have the right to choose his own physician and hospital except for minor injuries or in cases where he is incapable of making a decision. Probably in the case of many workers the physician chosen by the employer is as good as or better than the one the worker would choose but the right to choose except in emergencies should be with the patient or his next of kin. The employer must be prepared to provide physician and hospital and the injured employee must be treated in emergencies but the employee should have the right to change to a physician of his own choice.

Lastly comes the vexed question of payment for hospital service. On what basis shall it be fixed? Shall it be at a fixed rate per day throughout the state? Then in some sections the costs are greater than in others, some hospitals would be overpaid and some underpaid. Should the rate be fixed for a given community at a flat rate per day? The same inequalities still exist. The per capita costs vary widely in neighboring hospitals. If the rate is fixed at the higher per capita the business becomes profitable for the hospital with the lower costs, if fixed at the lower rates the hospital with higher per capita must operate at a loss and thus supply its charity to employers and insurance companies. There seems to be only one just solution to this problem. That is that hospitals shall be paid what it costs them to care for injured workers under the compensation laws, whether their per capita cost be six dollars or three dollars a day for the service rendered.

### THE MARY McCLELLAN HOSPITAL, CAMBRIDGE, N. Y.

(Continued from page 412)

family physician desire it, there will be no treatment given. The purpose is to obtain more exact knowledge of just how the children stand and if they do need treatment or operation to give advice on this point.

A well-trained resident staff on full time pay, backed by the regular visit of distinguished physicians and surgeons from the large cities has brought into a rural community a unique and

very high class service. In this service all patients participate, whether they can pay or not, the ward cases receiving as careful treatment as the private patients. The group consultation is a special feature of the working plan.

This service has been made possible by a generous endowment of \$750,000, and by the determination that the patient should be the first consideration. When it was decided to start a school of nursing, the trustees and superintendent were determined the school should represent as high ideals as those established by the hospital, and this has been made possible by the affiliation with Skidmore College.

### RADIO DEVELOPMENTS IN MILITARY AND NAVAL HOSPITALS

The Bureau of Standards, Washington, D. C., is assisting in the technical phases of current movements to equip many thousands of hospital beds with radio service.

Since the middle of March of this year S. L. Rothafel, managing director, Capitol Theater, New York, N. Y., and his broadcasting artists have been raising funds for the installation of radio in the United States military service hospitals. A technical committee of government experts (representing the Signal Corps, Navy Department, and Bureau of Standards) is furnishing technical advice as to the material and method of installation for these hospitals. The first hospitals equipped were Walter Reed General Army Hospital, Naval Hospital, and Mount Alto Veterans' Bureau Hospital, all in Washington, D. C.

The general system employed is to use one receiving set and a powerful amplifier to supply the entire hospital, each patient being provided with head telephone receivers which can be connected or disconnected at will. The amplifier used is capable of supplying about 3,000 headsets in parallel, and by reducing the number of loud headsets and using suitable transformers a number of speakers may also be used in the various rooms.

At Walter Reed Hospital 1,500 headsets and six loud speakers are used, the loud speakers being provided for assembly halls only. This equipment requires the services of one man continuously while the set is in operation to control the volume of sound delivered to the patients. The set used is capable of receiving distant as well as local programs, but because of disturbances that may be introduced in distant reception, local programs are used except on special occasions where a program of very general interest is being broadcasted from a distant station. The installation includes a microphone which is used for the distribution to the patients of programs given in the auditorium or elsewhere in the hospital. This microphone makes it possible for any person to address all the patients of the hospital simultaneously. The installation has been in operation for four months and has been very satisfactory.

The work of equipping other hospitals is being continued and the material for all service hospitals in the vicinity of New York, N. Y., has been ordered. The aim of the movement is to make it possible for every patient in all the military hospitals of the United States to listen to radio programs. A large part of the money for this purpose has been raised and the campaigns are being continued. Similar campaigns for the equipping of non-military hospitals in various places have been begun.

## AN APPROACH TO THE PREPARATION OF A HOSPITAL BUILDING PROGRAM\*

**V**ERY often in approaching the preparation of a building program an initial figure is given which bears no real relation to actual needs.

In determining the size of a hospital, the population to be served is the first element to be considered; numbers, character, and rate of growth call for separate attention. Relevant to this study are the economic resources of the community, the prevailing occupations and their health hazards, the manner in which families and individuals without families are housed, hospital facilities already available in the neighborhood, the sickness rate of the community, the presence of groups possessing special characteristics or customs and religious beliefs, insofar as such beliefs are likely to affect the attitude of the people toward the proposed sectarian or non-sectarian hospital.

What proportion of the total number of patients to be cared for are likely to be in a position to meet the cost of private rooms? How many will seek, or should be persuaded to accept, semi-private accommodations? Shall semi-private wards contain two, three, or four beds each? For how many may "public" ward beds appropriately be provided? What is the largest acceptable size for a public ward?

If the building program has to do with the expansion of an old hospital, to what extent can the existing buildings be adapted to the larger program? Are these buildings reasonably safe as fire risks?

What is the contemplated scheme of clinical organization? What reserves should be provided to meet the needs of specialized wards in the future?

### Site Should Be Defined

The characteristics of a site appropriate to the present and future building program should be

defined before a selection is made. The volume and character of the work to be done and the residential distribution of the population to be served, are relevant to the problem. From the standpoint of construction alone, size, shape, contour, and character of soil are to be reckoned with. Water supply and drainage will be considered as a matter of course. Accessibility is an item of some importance. In crowded cities in which acreage is scarce, hospitals should make every effort to obtain sites adjoining public parks.

In the case of a hospital in which the various clinical specialties are at the outset either unrepresented or incompletely represented, the subsequent introduction of additional clinical departments may be taken for granted; while in the case of a hospital which is completely organized at the outset, the probable rate of growth of each of the different clinical divisions must be considered.

Are separate convalescent wards desired, or is there to be an affiliation with a branch hospital for the treatment of convalescents?

In planning a university or teaching hospital special needs are encountered. Lecture rooms and library must be featured, the out-patient department expanded and modified, living accommodations for residents increased, and locker rooms, toilet accommodations, lunch rooms, and separate entrances for medical students provided.

In some hospitals the clinical records of both in- and out-patient departments are assembled at a single center. It is wise to provide space in the record room proper for the accumulation of the records of at least ten years.

It is desirable to locate the library near the clinical record room.

The number of operating rooms should be calculated with relation to the total number and kinds of surgical cases to be treated, and with due regard to the organization and working methods of the staff.

### Service Value

**W**HEN a tentative building program has been drawn up it is wise to pause and consider what it signifies in the way of outlay. This can best be done by the preparation of rough preliminary plans and here, as well as in the subsequent modification of the program, the knowledge and experience of experts can be advantageously brought into play. Nothing should be either taken into or excluded from the building program without a competent and impartial appraisal of its service value.

\*Abstract of report of the committee on building—construction, equipment, maintenance, submitted at the meeting of the American Hospital Association, Buffalo, N. Y., October 6-10, 1924, S. S. Goldwater, M.D., chairman.

All of the laboratory work of a hospital of moderate size may be done in a single large room, but in that case the equipment of the room will be most varied. Separate rooms are usually wanted for (1) pathology, (2) bacteriology and immunology, (3) biological chemistry. The manner in which the house staff (and medical students, if any) are to participate in the laboratory work of the hospital should be defined.

The staff of the department of radiology should decide whether all x-ray examinations and treatments are to be carried out in a central department, or whether certain combined x-ray and clinical examinations and treatments are to be done elsewhere. The use of a portable x-ray unit at the bedside should be considered.

Other diagnostic and therapeutic divisions are the cardiographic laboratory with its special system of wiring; the respiration laboratory; a department for radium treatment; physiotherapy, including hydrotherapy, and thermotherapy, and mechanotherapy; occupational therapy, and dentistry.

Receiving or observation wards, facilitate greatly the proper classification and handling of newly admitted cases. Emergency treatment room or rooms and the ambulance entrance should be close to the receiving wards.

Balconies, roof wards, and solariums comprise an important group of facilities from the standpoint of effective medical care and health.

### What Out-Patient Department May Include

The out-patient department may include separate accommodations for the departments of medicine, pediatrics, obstetrics, neurology, mental hygiene, dermatology and syphilis, surgery, diseases of the eye, ear, nose, and throat, gynecology, orthopedics, gastrology, dentistry, infant hygiene, and adult hygiene. In estimating out-patient capacity, the architect should remember that the capacity of a department may be doubled by holding two daily sessions instead of one. The utilization of an out-patient department for teaching purposes effects the character of the plan.

For the planning of the administrative or business center of the hospital, certain information is requisite: the number and functions of the executive officers; the method of receiving, registering, and admitting patients; the character of the social service organization and its office requirements; the number and duties of officials connected with the training school for nurses; the number and duties of heads of other administrative departments, for whom offices are required; the number of employees in the accounting department.

Among the topics to be considered in connection with the nurses' home are total capacity; teaching facilities; library, reception and living rooms; students' bedrooms; lavatory, bathing, and toilet facilities; quarters for attendants or nurses' aids; balconies and sleeping porches; nurses' infirmary; recreation room and gymnasium; tennis courts and swimming pool; servants' quarters; linen, trunk, and storage rooms; students' kitchenette and hand laundry; food service.

Local customs and local circumstances will determine how large a percentage of the domestic and other miscellaneous workers should be lodged on the hospital premises.

### How to Plan Food Service

No attempt should be made to plan a hospital kitchen (and its accessory serving rooms) without previous agreement upon a food service scheme. It is essential to know not only the number of persons to be fed, but whether food is to be sent to the wards and private patients' corridors in bulk or on individual trays; whether trays are to be prepared in the main kitchen or adjoining the wards; whether there is to be a special diet kitchen for "feeding" cases; whether pupil nurses (and pupil dietitians, if any) are to be taught in the main kitchen or the diet kitchen.

The laundry should be planned with relation to the volume and kind of work to be done, and should be located in a manner convenient for service.

Whether the clothing of ward patients is to be cared for in rooms adjoining the wards or in a central clothes room for patients is a matter of hospital policy.

### Engineering Problems

Will the hospital produce its own light and power? What provision should be made for breakdown or emergency service? What fuel is to be used—coal or oil? How accessible are reliable sources of supply? What should be the extent of the storage facilities? In what location will the stack be least objectionable? An agreement should be reached on fundamental principles of air supply and treatment.

Shall the heating system be hot water or steam? Is the city water supply ample or must it be supplemented? Is a water filtration plant necessary? Is water sterilization essential, and to what extent? Is a sewage disposal plant required? What are the legal and what the practical requirements in the matter of fire stairs, fire escapes, fire apparatus, and signal systems? Is the garbage to be

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## CLINICAL AND SCIENTIFIC EQUIPMENT AND WORK

**D**URING the past year the A. H. A. committee on clinical and scientific equipment has had under consideration three subjects: diabetes—its treatment by insulin; physiotherapy in hospitals, and laboratories in hospitals.

When insulin is administered in proper amounts to a diabetic patient it causes sugar to be so utilized that the urine is sugar free and blood sugar normal. It allows the patient to be properly nourished.

The first step in the treatment (except where there is coma or severe acidosis) is the determination of the patient's sugar tolerance. This may be determined by diet alone, or by diet plus insulin. One of the difficulties of insulin therapy is the growth of the patient's sugar tolerance, and care must be taken to diminish the dose of insulin as the natural tolerance grows.

Insulin is given by hypodermic injections. In administration, as a rule, the dosage should be five-eighths of the total amount just before breakfast and three-eighths just before supper. Milder cases may be given one dose a day. There is a singular lack of pain and reaction following injections.

The following are symptoms of over-dosage: Hunger; slow mentality; sudden weakness; sudden increase in pulse and respiratory rate; visual disturbances—double vision or blurring; general tremor; sweating; unconsciousness and convulsions.

In milder cases treatment of over-dosage resolves itself into advancing the meal hour or giving patient twenty grams of milk chocolate. In severe cases the treatment calls for adrenalin hypodermically, and if unconsciousness occurs 30 cc. of fifty per cent glucose solution intravenously.

Insulin is not a cure for diabetes, but is the most effective therapeutic agent we have. However, along with its value must always be remembered the value of the education of the patient regarding his diet.

Future problems for the treatment of diabetes by insulin are:

(a) Administration by mouth, (b) cheaper cost of manufacture, (c) properly equipped department in hospitals for instruction in and treatment of this disease.

### What Physiotherapy Comprises

Physiotherapy is the utilization of the physical

forces of nature in the treatment of diseases. It may be classified under four headings: Electrotherapy; radiotherapy; hydrotherapy, and kinesi-therapy.

Such a department should invariably be placed in charge of a competent physiotherapist.

In electrotherapeutic treatment the forms of electricity used are those by which can be obtained chemical, mechanical or thermal effects. The currents used are: (a) galvanic, (b) faradic, (c) sinusoidal, (d) high frequency and (e) static. Of these five the most valuable and extensively used are (a), (c) and (d). The faradic was formerly used extensively, but has now been largely replaced by the sinusoidal current. The extravagant claims made for the static current have caused considerable skepticism among physicians. It has, however, some value.

In radiotherapy the simplest forms for treatment are the photophore and the electric light cabinet. Another form is the quartz mercury vapor light, which replaces and is even more satisfactory than sunlight. Under this classification are also included x-ray and radium.

The equipment for hydrotherapy treatments should be: Two electric light cabinets, two six-foot baths with mixing valves, two sitz baths, two whirlpool baths, needle spray and shower, and douche apparatus.

Kinesitherapy is the treatment of disease by movements or exercise. The department should have facilities for giving both manual and mechanical exercise.

### How to Locate the Laboratory

In securing data on the subject of laboratories, questionnaires were sent to hospitals of the United States and Canada and over 900 replies received.

The staff makes use of the laboratory in direct ratio with the efficiency and number of employees and the adequacy of the service rendered.

The prime essentials to be considered in regard to the location of the laboratory are:

(a) Space; (b) light—north is preferable; (c) accessibility to the visiting staff—the laboratory should be one of the consulting centers of the hospital; (d) ease of getting specimens to the laboratory from floors and operating rooms, and of returning laboratory reports.

There is no general rule applicable to the number of employees for bed capacity, although less than two people should be employed in the laboratory of a hospital of fifty to one hundred beds. This ratio must be increased as the number of beds increases, for example, a hospital of two

\*Abstract of the report of the committee on clinical and scientific equipment, submitted at the conference of the American Hospital Association, Buffalo, N. Y., October 6-10, 1924, K. H. Van Norman, M.D., chairman.

hundred beds should have not less than eight employees.

For laboratory directors and pathologists the average salary is \$4,500 per annum, and for the technicians \$1,800 per annum with meals. In many instances the basis of remuneration of the pathologist is the payment of a salary plus a percentage of the income derived by the hospital from charges made for the work done. This latter procedure is not desirable. A straight and liberal salary should be paid. Chemists, bacteri-

ologists and serologists should receive from \$1,800 to \$3,000 per annum.

Laboratory charges should be made on a basis which will sustain this important branch of hospital service and yet make it available to all classes of patients. Such charges should be either a flat rate or the service should be included in the per diem charge, and of these two the latter is preferable.

Laboratory equipment should be ample for carrying on all types of work.

## SUGGESTED STANDARDS FOR CLEANING\*

THE special committee on cleaning was appointed to make a thorough survey of all types of cleaning done in hospitals, to study and classify the results obtained, and to make definite recommendations concerning methods and materials.

The work has extended over eighteen months and has been about equally divided among the various members. The report itself has necessarily omitted much interesting data assembled in the course of the work, and has included only conclusions and end results. It is believed that hospitals have long felt the need of concise information on the subject of cleaning and the committee recommends this year's report to the study of superintendents, housekeepers, nurses, dietitians, and others having interest in cleaning processes.

### Use Report as Reference Book

The committee is assisting in a wide distribution of the report. Hospital officers are earnestly urged, if they agree with the findings, to see that the methods recommended are instituted in their own hospitals. The report as printed could very well be used by hospital employees as a reference handbook in connection with the daily work of the institution. The report will not serve its intended purpose if it is read once by the head of the hospital and then passed on to the oblivion of a filing cabinet or bookcase. Copies should be in the hands of each department head who is responsible for any of the cleaning performances covered. Extra copies may be obtained from the secretary of the association as long as the supply lasts.

No attempt will be made here even to summarize the details of the report. The report itself has been prepared in as brief form as possible so that further condensing is not practical.

\*Abstract of report of committee on cleaning, submitted at the conference of the American Hospital Association, Buffalo, October 6-10, 1924. Chairman, C. W. Munger, M.D., director, Grasslands Hospital, Valhalla, N. Y.

The work of the committee has been divided as follows: (a) cleaning of floors, walls, windows, window screens, rugs, carpets, upholstered furniture, plumbing, and metals; (b) terminal disinfection (following contagious disease); (c) laundry; (d) care of surgical instruments and rubber goods; (e) cleaning of dishes and kitchen utensils.

In addition to complete data on the subjects mentioned, the report also contains a reprinting of specifications for the purchase of soaps and cleaning compounds. It is certain that these specifications will prove of value to any who use them.

One of the general points which the committee has stressed is that there is no universal cleaning compound; that the compound and the process must be carefully fitted to the particular cleaning problem, although the number of cleaning compounds used in any institution should be kept to the minimum number which will do the work.

The committee has also emphasized supervision of workers and *actual classes* for instruction of workers. The committee believes in the setting up of definite cleaning formulas for each type of service and in limiting the staff to them. Fool-proof preparations are always to be preferred to materials whose use is so complicated as to require closer supervision than is practical in the rush of the hospital's daily work.

### Cheap Products Increase Labor Expense

It is advised that machinery be used wherever it is more economical than hand work and equally efficient. Hospitals are warned against the use of cheap cleaning materials which may seem to decrease the cost of supplies but which are very likely to increase labor expense. It is also advocated that systematic charts of cleaning progress be kept.

The committee recommends the purchase of machines and materials from firms whose prac-

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tice is to sell service first and commodity last and who deal honestly and fairly with our institutions.

This report is presented with the hope that it will help to standardize a part of hospital performance which has been almost without standards. Most American hospitals have been

clean in the past, but often only after undue effort, great expense, and unnecessary marring of buildings and equipment. This report contains little that is new and is not all-inclusive. Properly used, however, it will provide a solid foundation upon which to build a rational system of cleaning.

## THE A. H. A. AND INTERN SERVICE\*

**R**ECOMMENDATIONS relating to intern service must consider the education of the intern, the welfare of the hospital including patient, staff and management, the interest of the medical school and the legal requirements of the state board of licensure. The recommendations of the intern committee of the American Hospital Association, although primarily for the consideration of the American Hospital Association, have been prepared with the assistance of the Association of Medical Colleges as representing the medical schools, the American Medical Association as representing the intern, the American College of Surgeons as representing the hospital staff, and following correspondence with various state boards of licensure.

It is important to remember that the primary function of hospitals is the care of the sick; their secondary functions are teaching and research.

### Summary of Recommendations

1. That the schedule of essentials in a hospital approved for interns as prepared by the council on medical education and hospitals of the American Medical Association be accepted as a standard by hospitals and medical schools.

That the trustees of the American Hospital Association consider the advisability of making application for representation in the council on medical education and hospitals of the American Medical Association, and take such action as they may determine.

2. That the American Hospital Association request the adherence of its members to the relationship between hospital and intern as set forth in the schedule of essentials in hospitals approved for intern service, and that it collect information regarding the non-adherence of hospitals to this schedule and the repudiation of agreements by interns, that it publish such portions of this information as may be desirable, or furnish this information to other organizations, such as the American Medical Association, the American Col-

lege of Surgeons, and the Association of American Medical Colleges.

3. That the American Hospital Association collect and supply to medical schools data relating to the intern service in various hospitals, and to hospitals similar data regarding graduating students in medical schools.

That the American Hospital Association request its members not to appoint interns or to hold examinations for interns until the student has completed three and a half years of medical study; preferably between March 15th and April 1st.

That individual arrangement be allowed hospitals as to the mode of selection of interns, by certification from medical schools, by appointment on recommendation without examination, or by examination. While recognizing the inherent difficulties we still recommend that wherever possible, the hospital inspect the candidate and the candidate inspect the hospital.

4. The establishment of the following forms of hospital internships and residencies:

First: rotating internships of one year, with service in medicine and surgery—medicine to include pediatrics and laboratory work and surgery to include obstetrics; this minimum may be lengthened to eighteen months or two years provided it is warranted by increased educational values; such rotating internships to be supplemented by residencies of one year or more for graduate interns. These are essential for the proper care of patients and to provide opportunities for those who wish to obtain further proficiency before entering practice.

Second: non-rotating internships in certain hospitals with highly organized intern and resident systems with continuous service in one department of medicine. If the internship is for one year and the work is limited to medicine or surgery, the intern should be encouraged to complete both services. For a longer period the work should be so modified as to include some training in other departments. The combination of a short general training in all major departments followed by a continuous service in one depart-

\*Abstract of report of the intern committee, submitted at the conference of the American Hospital Association, Buffalo, N. Y., October 6-9, 1924, Nathaniel W. Faxon, M.D., chairman.

ment offers a very desirable form of internship.

Third: residencies or special internships in special hospitals, such as eye, ear, nose and throat, orthopedic, obstetrical, children's, mental, tuberculosis, to be taken only by interns who have completed the minimum intern year. Residencies should also be offered in general hospitals for further training in the major departments, as noted above, to supplement internships in such

hospitals, where this arrangement can be made.

Fourth: That there be established residencies in suitable hospitals not approved for intern training, to be filled by graduate interns, that these hospitals may have the benefits to be derived from a resident physician and that graduate interns may have wider opportunities for further training before undertaking independent practice.

## TUBERCULOSIS AND THE SMALL HOSPITAL\*

By T. B. KIDNER, CONSULTANT ON INSTITUTIONAL PLANNING, NATIONAL TUBERCULOSIS ASSOCIATION, NEW YORK, N. Y.

INASMUCH as the American Hospital Association passed a resolution in 1921 urging the establishment of tuberculosis wards in general hospitals, it will not be necessary to consume much time in reciting the reasons which led this association and other national organizations to take such action. Some brief references must, however, be made to those reasons.

The relation of the general hospital to tuberculosis has, in most cases, been one that could not be defended on logical grounds. In very few hospitals is an "open" case of tuberculosis welcome, and in many places patients in any stage of the disease are actually excluded.

It can scarcely be gainsaid that this is due to the widespread campaign against tuberculosis and its infectious character; a campaign which has not only succeeded in educating the lay public in the possibility of the disease being easily communicable, but has also resulted in a pretty general development of phthisiophobia—a morbid dread of the disease—amongst the medical and nursing professions, as well as amongst the laity.

Today, when leading tuberculosis specialists do not hesitate to aver that the possibility of com-

municating the disease from adult to adult is remote, and that most of us become infected in childhood, the morbid and irrational fear of it is still widespread and dies but slowly, and is reflected in the attitude of many hospital authorities. In this connection, there cannot be too often

reiterated the well attested statement that of all places, a properly conducted hospital or sanatorium for tuberculosis is least likely to cause the disease in the bodies of fairly healthy persons, leading a regular and healthy life.

While some medical authorities today consider that there is a possibility of communicating the disease from adult to adult under conditions of prolonged, intimate contact such as is found among workmen employed about the same machine or bench, the danger to nurses of contracting tuberculosis from patients under their care is indeed remote.

The formal exclusion of tuberculosis from general hospitals has had serious results in the loss of teaching opportunities. Dr. George Dock, a leading authority on tuberculosis puts it thus: "The commonest disease, a disease of the most diverse symptomatology, one requiring for its early detection the most expert care, could not properly be taught to medical students, because hardly any medical schools controlled institutions in which tuberculosis patients were cared for." From the

### The General Hospital and Tuberculosis

THAT tuberculosis can be treated advantageously in the general hospital was convincingly brought out by Mr. Kidner before the small hospital section of the Buffalo Conference. General hospitals can best provide the needed facilities for proper diagnosis and care of border-line cases, and general practitioners need the training which the care of these cases would afford. Then, too, the general hospital could provide for patients who are too ill to be benefitted by sanatorium treatment. Mr. Kidner gives the following formula for determining the number of beds which the general hospital should provide for tuberculosis: Divide the total number of annual deaths from tuberculosis in the community over a number of years by five, and add to the result thus obtained one bed for every 15,000 of the population.

\*Paper read before the twenty-sixth annual conference of the American Hospital Association, Buffalo, N. Y., October 6, 1924. The writer acknowledges indebtedness to Dr. H. A. Pattison, supervisor of medical service, National Tuberculosis Association, for helpful criticism and suggestions which have been incorporated in this paper.

patient's viewpoint, Dr. Dock says, "Tuberculous patients suffered because they could not readily and near at home get the sort of treatment they needed, and that hospitals should furnish."

Dr. Thomas McCrea, another well-known authority, says: "Does it not seem an unfortunate fact that the disease which as regards frequency of occurrence stands at the head of the list should be regarded as a thing apart from the daily work of many of the profession?"

One more quotation from an authority must suffice to show the urgent need for the provision of accommodation for cases of tuberculosis in general hospitals. Dr. Wm. S. Thayer, of Johns Hopkins Hospital, Baltimore, Md., in answering the question as to what should be done to remedy the present unfortunate state of affairs, said:

"The establishment of wards for the treatment of tuberculosis in all teaching hospitals is the first requisite for proper instruction in the care of the disease. Every general hospital should have a ward or wards for the temporary treatment of pulmonary tuberculosis.

"This would be of great advantage to the public and to the patient, for such a ward will offer to many patients the opportunity to be tided over those emergencies which, without the advantages of enlightened care, are often immediately dangerous to life. Such wards need not become homes for the incurable; and they may serve a very good purpose in the temporary care of the chronic tuberculous. Such wards would be of immense advantage to the student, because the presence of these patients offer to him and to the staff opportunities for studying a large number of conditions and of meeting many problems and emergencies against which they are sure to be called upon to contend in their subsequent practice."

It would seem, therefore, that there is a strong argument for the inclusion of tuberculosis beds in general hospitals from the point of view of providing much-needed opportunities for the training of interns, general practitioners and nurses. In this connection, it may not be out of place to call attention to the growing tendency to arrange for affiliation between a nurses' training school and a neighboring tuberculosis sanatorium. In the case of the small hospital, with a small nurses' training course, this seems to me to be particularly desirable.

As a former resident for many years of our sister nation to the North, it gives me pleasure to point out that the necessity for providing for tuberculosis in general hospitals is well recognized in Canada.

In the directory of Canadian agencies for the diagnosis and treatment of tuberculosis, issued by

the Canadian Tuberculosis Association, there are notes indicating that in the provinces of Alberta, British Columbia, Manitoba and Saskatchewan all hospitals receiving aid from the provincial governments must set aside ten per cent of their beds for tuberculosis.

In the province of Ontario, it is stated that "No hospital receiving provincial aid can refuse admission to the tuberculous."

If it be granted that it is desirable to provide for tuberculosis in general hospitals, a consideration of the essentials to be borne in mind in making such provision may be of some service.

A somewhat wide and varied acquaintance with tuberculosis specialists, and with institutions of many types, leads me to put in the forefront of essentials in the care and treatment of tuberculous persons facilities for proper diagnosis. Even in sanatoriums for tuberculosis, such facilities are often lacking, but a tuberculosis section in a general hospital would have at its disposal all the technical resources found in every good general hospital today. Nose and throat specialist, ophthalmologist, general and gynecological surgeon, pathological and bacteriological laboratory, x-ray department—all are necessary in the difficult, and usually prolonged, differential diagnosis of the border-line case, since symptoms closely simulating those of tuberculosis are sometimes indicative of other diseases. Differential diagnosis is also necessary in many cases of tuberculosis where the precise form of the disease is not discoverable by the usual clinical examination.

In effect, the tuberculosis section of a general hospital fulfills two functions for the community; first, it serves as a diagnostic center to which all actual or suspected cases of the disease can be referred; and, second, it provides for patients too ill to be removed to a distant institution, or to be benefitted by sanatorium treatment.

It would also serve as a clearing center from which patients with a good prognosis could be sent to a sanatorium for the prolonged convalescence necessary to effect an arrest of the disease. In this connection it seems well to emphasize a fact that was apparently disregarded in planning many of the early sanatorium buildings; namely, that a hopeful, recoverable case is quite often a hospital case for several months. All over the country one finds such cases in sanatoriums which have no adequate accommodation for bed cases, and in consequence the time and effort of the medical and nursing staff is unnecessarily taken up in trying to care for bed cases in quarters wholly unsuitable for them.

From the point of view of planning accommoda-

tion for the care and treatment of the patients, the familiar, well-tried and accepted formula of rest, fresh air and nourishing food still holds the premier place, but in recent years has been supplemented more and more by therapeutic treatment of various kinds.

For the latter, the technical resources of the ordinary general hospital mentioned above, plus dental treatment and heliotherapy, will provide all that is necessary.

To enable the formula of rest, fresh air and nourishing food to be applied, very slight modifications of the usual hospital type of room and ward are required for the patients' quarters. In point of fact, for some years past the type of accommodation provided for patients in tuberculosis hospitals and sanatoriums has been approaching more nearly that of the general hospital; the chief difference being that adequate provision must be made for sleeping and resting in the open air.

For the community which contemplates the establishment of a tuberculosis section in a general hospital, the first consideration is the number of beds which should be provided. As a working approximation, the following simple formula will, it is believed, prove fairly satisfactory in determining the number of beds necessary to meet the local needs:

Divide the total number of annual deaths from tuberculosis in the community (average for several years) by five, and add to the result thus obtained one bed for every 15,000 of the total population.

Example:      Population = 100,000  
                   Annual deaths =     90  
                    $90 \div 5 =$          18 beds  
                   1 bed for each 15,000 = (say) 6

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24 beds

The total number of beds having been decided upon, the nature of the accommodation should next be considered. While local conditions sometimes cause a variation in the proportion of male and female cases, it is well to divide the beds equally between the sexes. If at any time one sex outnumbers the other, the provision of a generous proportion of single rooms will enable an adjustment to be made without difficulty. Reference was made earlier to the marked tendency, in planning for tuberculous patients, towards the general hospital type of accommodation and this has been particularly notable in the provision of single rooms in larger proportion; also in the movement away from interior units of large capacity—the old "open ward."

For the tuberculosis section of a general hos-

pital, at least fifty per cent of the beds should be in single rooms; the rest being in four-bed wards, sub-divided into two-bed cubicles by "stall" partitions.

Porches are not necessary for the single rooms, as all the fresh air necessary for a patient who is seriously ill can be obtained from the windows, although there should be available a porch to which a patient could occasionally be wheeled in a cot. Also, the windows of the rooms should be of a type that will not only admit light and air, but will, in addition, provide protection from rain. Double-hung sashes, and sashes of the casement type, do not meet the last-named requirement, and windows of the awning type, pivoted on the sides to open outwards, are therefore to be preferred. Care must be taken, however, to select a type of window that does not require a clumsy and unsightly box screen on the outside.

#### Porch Should Adjoin Dressing Room

For the four-bed wards, sleeping porches should be provided throughout. Various types of porches are in use, but whatever type be selected it should meet the requirement that the porch adjoin a room which can be used for dressing and into which the patients' cots can be wheeled in severely cold weather.

In the southern part of the United States, it is not necessary to enclose the porches with glass, but glazed porches should be provided throughout the parts of the country where severe weather is experienced, if only for a comparatively short season each year. It is, perhaps, unnecessary to add that all external openings must be properly screened.

Comfortable, enclosed day or sitting rooms are also necessary—one for each sex. The service or auxiliary rooms differ but little from those of an ordinary hospital. It is advisable to provide a separate diet or ward kitchen, and all dishes and tableware used by the patients should be kept in the kitchen, which should be equipped with a small, sterilizing dish-washer.

Small dining rooms (one for each sex) should be provided for patients able to leave their beds.

While on the subject of the feeding of tuberculous patients, it may be well to point out that the ideas which formerly were held regarding the necessity of special feeding for such patients have been almost wholly abandoned. Of course, for patients who are acutely ill with tuberculosis, as with any other disease, special diets are necessary, but this feature will present no difficulty in any general hospital. For patients who have reached the convalescent stage, a well balanced, generous diet, with plenty of milk, is usually pro-

vided; but observations in a great many institutions in recent years indicate that in very few of them do the physicians prescribe the large quantities of eggs and other rich nitrogenous foods formerly believed to be necessary. In short, the dietary problem for tuberculous patients is quite simple and presents no difficulties that are not found in any hospital.

Infective discharges must, of course, be cared for as near the source as possible. If paper-lined sputum cups are used, a covered receptacle or waste can should be provided for the used linings; preferably, near a water section so that it may be used by ambulant patients. Used paper napkins would also be placed in this receptacle. Where bed cases only are present, the waste receptacle should be placed in the utility room. Paper bags to fit the receptacle should be provided and the bottom covered with an inch of fresh sawdust. At intervals, an attendant takes out the bag, puts in a fresh one, and carries the bag and its contents to the central incinerator.

As an alternative, built-in incinerators are often provided and the sputum cups and paper napkins put directly into it by the nurse or patients.

### Open Deck for Heliotherapy Work

For natural heliotherapy (sun treatment) an unglazed porch or open deck is necessary. As the patients are unclothed during the period of treatment, the porch or deck must be so located that it cannot be overlooked from any point. For a small number of patients, one deck, to be used by men and women alternately, say, morning and afternoon, can be made to serve, but two decks should be provided wherever possible, and always when there are many patients to be treated.

For artificial heliotherapy (quartz lamp, etc.) it is well to provide a room for each sex, although it is quite feasible to give lamp treatment in an ordinary single-bed room.

One other point will complete this brief statement of the physical requirements for the care and treatment of tuberculous persons. While tuberculosis specialists believe more than ever in the absolute necessity and efficacy of rest, there comes a time in the history of the case which is progressing towards recovery when exercise can play its part. As it has been well put, "Rest saves life—exercise makes well."

Exercise for a tuberculous patient almost always begins with gentle walks in the open air, on ground that is level, or nearly so. In some sanatoriums, walking forms practically the only physical exercise during convalescence, being gradually increased as the patient's condition improves. In others, light exercise is provided by in-

teresting work in arts and crafts, occupational therapy, in addition to walking.

If, as suggested above, the general hospital acts as a clearing house, and the patients are sent to a sanatorium for the prolonged convalescence, the foregoing remarks as to heliotherapy and exercise will not apply. There are, however, many communities where the tuberculosis section in the general hospital will treat patients throughout the course of the disease and in all such places provision for walking in the open air must be made.

To sum up, there is abundant evidence of the need of provision for tuberculosis in general hospitals, whether the community be large or small.

First, for the sake of the patients themselves; second, to afford opportunity for physicians and nurses to learn tuberculosis, and thereby, later on, to benefit humanity.

If proper precautions, differing in no whit in principle from the precautions observed in other infectious diseases, are taken there is no danger to the hospital personnel or to other patients.

There are no specially difficult problems that need deter a small general hospital from undertaking to care for tuberculous patients, and very little special equipment is required.

Perhaps I may most fittingly conclude by quoting a remark made to me by a general hospital superintendent of long experience, who, in response to my question as to his attitude on this matter, said "Of course I am in favor of making definite provision for tuberculosis in general hospitals, particularly in the smaller communities. As it is, we have open cases of tuberculosis, known and unknown, in practically every hospital, and it would be far better for all concerned if definite provision were made, and the present risks of the spread of infection thereby eliminated."

### ILLINOIS HOSPITAL SOCIAL WORKERS OFFER HEALTH LECTURES

A series of eight lectures in medicine and industry are being given under the auspices of the Illinois district of the American Association of Hospital Social Workers, room 1800 N. State Street, Chicago, Ill. The lectures will be given from 3 to 5 o'clock every Monday afternoon from November 3 to December 8, 1924.

The following series of lectures has been scheduled: November 3, "Cardiac Disease and Industry," by Dr. Walter W. Hamburger; November 10, "Venereal Disease as it is Related to Industrial Problems," by Dr. Homer K. Nicoll; November 17, "Tuberculosis in Occupation," by Dr. James E. Britton; November 24, "Rehabilitation of the Physically Handicapped," by Dr. Harry E. Mock; December 1, "Mental Hygiene in Industry," by Dr. Lewis J. Pollock, and December 8, "Hospital Social Service and Employment," (speaker to be announced). The two lectures of the series held in October were on the subjects of health and employment and prevention of industrial accidents.

## STANDARDIZING HOSPITAL DIETARY SERVICE\*

**T**HE report of the committee on foods and equipment for food service deals with the following specific subjects:

1. Methods of making the diet fit the patient:  
The dovetailing of ward and private room food service with reference to good food, variety and economy.  
Economical variation of weekly menus.  
Applying the teachings of science regarding food supply.  
An outlined plan for instructing patients requiring dietetic treatment.
2. Means of effecting kitchen economies:  
Location of kitchen.  
Suggestion regarding construction.  
Equipment.  
Floor diet kitchens.  
Tray covers—cloth as compared with paper.  
Devices which facilitate economy and service.  
Garbage.
3. Data on milk formula kitchens:  
Construction.  
Equipment.
4. Food routing in a 300-bed central diet kitchen plan hospital:  
Weekly method of ordering provisions.  
Storeroom handling of supplies.  
Tray "set ups" at serving stations.  
Delivering trays to patients.

In making this study, questionnaires were sent to one hundred hospitals, large and small. Sixty-six replied. Fifty-nine of this group had dietitians in charge of the culinary department. Less than half indicated a satisfactory food service, and in this respect the medium-sized hospital seemed better off than the others. This condition of unsatisfactory food service in more than half of the hospitals probably holds throughout the country.

As it is customary to make some distinction between the service to ward patients and private patients and the metabolic patients must have even more distinctive service, there must necessarily be more than one menu planned, but this may be done in such a way that one service dovetails into the other and thus makes for a minimum of extra work.

In some instances, it will be necessary to serve a more expensive food to the private patients than is served to the wards, but there are still a number of foods which may be served to both groups without increasing expense. One great and general difficulty in trying to make the food fit the patient is that not all hospitals and dietitians realize that it is greater economy to give the ward patients a simple menu consisting of food of good quality than it is to buy cheaper

foods which may be of a quality that is not eaten. There must be close team work between the doctors, nurses and dietitians. No food service can be satisfactory without such cooperation.

The dietary department, being the department in which is put such a large percentage of the hospital's money, should receive more attention from those in authority than it is receiving in many hospitals at the present time. The standard of service should be as high, if not higher, than in any other department. This service should be maintained in a thoroughly systematic way. Regulations governing the issue of store-room supplies, receiving the daily requisitions from the wards, changes in diet orders and the returning of dishes or food trucks after meals should be observed as strictly as are regulations in any part of the house. If prompt delivery of meals is expected, the work in the kitchen must have as little interference as possible.

Indirectly, the food of the nurses and other hospital employees is related to the food of the patients. If the nurse's food is good and her meal hour pleasant, she goes back to the ward much better equipped, mentally and physically, to care for the patients.

It should be remembered that it is not always economy to buy cheap food or to engage cheap cooks, differentiating between cheap and inexpensive. The attendant waste is apt to make this an extravagant system. A menu should be so planned that a minimum of food material need be bought and handled, and a minimum of time and labor be required for its preparation.

The food service cannot be satisfactory in any institution without the interest of all departments—the executive, culinary, nursing and medical.

### Science and the Food Supply

The patient accepts the hospital, the medical treatment and the nursing care while he is in the hospital, as a new experience about which he has no definite knowledge, but his food is a matter of long and sometimes painful experience for him, and something about which he has definite opinions.

Too much emphasis cannot be placed upon the importance of enlisting the student nurse in the teaching staff. The doctor and the dietitian see the patient once a day, but the nurse serves his diet to him three times a day. Her knowledge of and her confidence in the diet will have a great influence in molding the patient's attitude toward his diet.

Teaching hospitals throughout the country are

\*Abstract of the report of the committee on foods and equipment for food service submitted at the conference of the American Hospital Association, Buffalo, N. Y., October 6-10, 1924, chairman, F. R. Nuzum, M.D., medical director, Santa Barbara Cottage Hospital, Santa Barbara, Cal.

meeting the demand for therapeutic diets by organizing departments of dietetics which serve as teaching centers for nurses, doctors and dietitian.

No nurse ever feels that two weeks is too long to spend on the children's ward diet service. Here she learns to put up formulas for the babies and to serve the children's diets.

It seemed advisable to organize a separate unit for serving gastro-intestinal diets. These diets are increasing in number and are varied enough to challenge the ability of anyone.

With the idea of the standardization of hospital diets in mind, we are working on a score card for judging diets. This score card is not only helpful in writing diets, but is proving very useful in teaching patients to write home diets. The points considered are: First, that the fuel value of the diet should be sufficient to maintain normal weight; second, the protein in the diet should be sufficient for growth and tissue repair; third, the ratio of carbohydrate to fat should be safe; fourth, the diet should provide enough residue to insure a normal bowel movement each day; fifth, the diet should furnish an adequate amount of minerals; sixth, the diet should contain a sufficient vitamin supply.

Keeping the normal dietary essentials before us, we have planned the diet order sheet to act as a guide for selecting and serving food. These diet order sheets are printed and put up in tablet form convenient for making carbon copies. When a corrective diet is ordered by the physician the dietitian makes duplicate copies of the diet as originally planned on the quantitative sheet.

## AN APPROACH TO THE PREPARATION OF HOSPITAL BUILDING

(Continued from page 418)

carted away or to be incinerated on the premises.

In a composite building, it is the *average* need that governs, rather than the absolute requirement of any given room.

Hospital authorities should be consulted concerning the materials to be used for walls, floors, stairways, partitions, built-in cabinets and trim, interior finish; concerning the width of corridors and the maximum and minimum size of patients' rooms; concerning nurses' stations and their equipment; concerning apparatus for sterilization, refrigeration, and vacuum cleaning; concerning the quality, kind, and number of plumbing fixtures to be installed in or adjacent to operating and treatment rooms, and in or adjoining patients' rooms; concerning the length and width of doors and windows and the height of sills; concerning the day and night illumination of wards and operating rooms and the use or omission of

transoms; in relation to the built-in clothes closets, portable lockers, time clock systems, the care of mattresses, the location and arrangement of storerooms and trunk rooms, the number and location of cleaners' closets, flower closets, supply closets, airing closets, the number, kind, size, and location of work and repair shops, and the need of a garage and a mortuary chapel.

Nothing should be either taken into or excluded from the building program without a competent and impartial appraisal of its service value. In the determination of issues of this character it is not altogether safe to be guided absolutely by the opinions of departmental enthusiasts, who have a valuable contribution to make, but who cannot reasonably be expected to see the problem of the hospital as a whole.

## HOSPITAL EXHIBITORS' ASSOCIATION HOLDS DINNER MEETING

The annual meeting of the Hospital Exhibitors' Association was held in the form of a dinner Tuesday evening in the mess room of the armory. Over two hundred exhibitors and friends were present.

The meeting was devoted largely to a discussion of ways and means of improving the work of the exhibitors' association and developing better relationship with the American Hospital Association.

Dr. Malcolm T. MacEachern thanked the exhibitors for their cooperation which had added much to the success of the conference.

In the course of the evening Mr. B. A. Watson, chairman of the executive committee, and Mr. Edward Johnson, secretary and treasurer, were presented with watches as a mark of appreciation of their untiring efforts on behalf of their fellow exhibitors.

The following are the retiring committee members: Mr. J. E. Hall, American Sterilizer Company, Erie, Pa., and Mr. H. L. Kaufman, Kaufman and Company, Boston, Mass. Succeeding them are Mr. Lawrence Davis, Lewis Manufacturing Company, Walpole, Mass.; and Mr. H. R. Applegate, Applegate Chemical Company, Chicago, Ill. Mr. Davis was elected secretary and treasurer to succeed Mr. Johnson, and Mr. Watson was re-elected chairman.

## NEWSPAPER PUBLICITY PLANS SUGGESTED

A new feature at this year's conference was the opportunity offered hospital executives to obtain publicity advice through the special service in relation to National Hospital Day. Mr. Ralph Welles Keeler, counsellor in publicity, Board of Hospitals and Homes, Methodist Episcopal Church, New York, N. Y., was in charge of this feature and was kept busy answering questions, outlining publicity plans and explaining the publicity exhibit. It was suggested that delegates upon returning home might help to focus the attention of newspaper readers upon the work of the hospitals in their communities by visiting newspaper people and giving them information concerning the conference.

During one of the round tables of the Buffalo conference a suggestion was heard in an undertone that what the association needed more than anything else in next year's program was a session devoted to the teaching of the technic of speaking loudly.

## SIMPLIFICATION AND STANDARDIZATION OF EQUIPMENT\*

THE committee on general furnishings and supplies of the American Hospital Association has been concerned during the past two years in discovering a way by which hospital authorities might secure a better understanding of hospital commodities, and what may be expected by the proper application of simplification and standardization as they apply to them.

To this end the committee secured the cooperation of the division of simplified practice of the United States Department of Commerce. This cooperation which was most enthusiastic has been justified by the results already accomplished.

### Save by Reduction of Varieties

The committee made a survey of hospital beds and found that there were thirty-three varieties in length, thirty-four varieties in width and forty-four varieties in height.

As a result of this survey a meeting was called under the auspices of the division of simplified practice of the United States Department of Commerce, which resulted in the adoption of the following recommendations:

1. For general hospital use.
  - (a) Length, inside distance between head and foot posts—78 inches.
  - (b) Width, of end angles of springs—36 inches.
  - (c) Height from floor to top of springs, inclusive of casters, etc.—27 inches.
2. For certain institutional use the need for a narrower bed is recognized. In these cases the recommended width is 33 inches with dimensions (a) and (c) the same as in 1 above.
3. For private room use, where a wider than standard bed is desired the recommended width is 39 inches with the dimensions (a) and (c) the same as in 1 above.

With the elimination of waste by the reduction of varieties the economic value of simplification and standardization is quite evident. The overhead of manufacturers must be greatly reduced and will undoubtedly in time show itself in a great decrease in the cost of commodities.

### Simplifies Blanket Problem

Although the varieties of bed blankets were not nearly so great as the variety of hospital beds, they were numerous enough to call for standardization and simplification. The survey showed that there were twenty-three sizes of wool and cotton mixed blankets manufactured from 1920

to 1922, and twenty sizes of cotton blankets produced in the same period. Upon the recommendations of the conference held to discuss the subject, the recognized sizes of bed blankets were reduced to twelve. Although this investigation was independent of the committee's work, the chairman of the committee represented the American Hospital Association in the conference.

The work that has thus far been done shows very definitely that simplification and standardization are to become important factors in hospital administration. Under proper application, the economic value cannot be over-estimated.

The recommendations of the committee are as follows:

1. That the association continue the study of hospital commodities for the purpose of simplification and standardization.
2. That an expert be employed to take charge of the work with the view of extending it over the whole field.
3. That the association give its cooperation to other organizations concerned in the simplification and standardization of commodities similar to or identical with those used in hospital service.

### NEW YORK DELEGATES FORM STATE HOSPITAL ASSOCIATION

A New York State Hospital Association was formed by a number of representatives of New York hospitals who assembled at the Buffalo conference. The meeting at which the new organization was formed took place Wednesday morning following the general session of the conference. The association will be a state branch of the American Hospital Association.

The following officers were elected for the first year: president, Mr. C. A. Lindblad, superintendent, Millard Fillmore Hospital, Buffalo; vice president, Miss Emily C. McCreight, superintendent, Arnot-Ogden Memorial Hospital, Elmira; treasurer, Miss Sara Burns, Memorial Hospital for the Treatment of Cancer and Allied Diseases, New York; secretary, Dr. Nelson Thomson, superintendent, United Hospital, Port Chester. The executive committee consists of Dr. George T. O'Hanlon, medical superintendent, Bellevue and Allied Hospitals, New York; Dr. Charles H. Young, superintendent, Hospital of the Good Shepherd, Syracuse, Mr. William J. McClain, superintendent, St. Luke's Hospital, Utica. These people were constituted a general committee of the association to outline plans of organization and conditions of membership.

### RESTAURANT SERVICE AT ARMORY

Because of the distance of the armory from most of Buffalo's hotels, arrangements were made with the Buffalo Catering Co., to serve regular luncheons at eighty-five cents as well as a la carte luncheon each day of the conference and a dinner on Wednesday evening.

\*Abstract of report of committee on general furnishings and supplies submitted at the conference of the American Hospital Association, Buffalo, N. Y., October 6-10, 1924, chairman, Miss Margaret Rogers, superintendent, Lafayette Home Hospital, Lafayette, Ind.

## MEANS OF IMPROVING HOSPITAL STATISTICS\*

THE report submitted by the committee on records and accounting at the Buffalo conference was in accordance with instructions from the board of trustees and was the fourth report submitted since the organization of the committee. The report supplemented the previous work of the committee, in that it reiterated and emphasized, in recording the hospital's performance, those principles which are believed to be fundamental and necessary to establish a common understanding of the subject.

In order to arrive at a clearer understanding of the outline of procedure submitted in the first report and the purposes which that report was expected to serve, each of the nine general divisions into which the subject of recording had been divided were discussed in detail, the principle involved was indicated and an attempt made to establish the results to be obtained.

The "chart of accounts" submitted in the original report was somewhat modified in the light of the experiences of various institutions that were communicated to the members of the committee and because the modifications seemed to improve the chart, without destroying the mechanism that had been set up. The suggested changes fit into the original scheme and, because of its flexibility, do not in any measure interfere with its operation.

The divisions of accounting, purchase and issuance, administration, professional service, nursing school, social service, out-patient dispensary, library and analysis of activity are given detailed discussion.

It must be recognized that a report such as this, dealing as it does with so many details, some of which appear at first glance to be of but minor importance does not lend itself to extensive discussion and requires careful and detailed study in attempting application to any particular situation.

It is believed, however, that wherever there is need for revision of present methods or where a new institution is seeking for a system of recording, the report will be of great assistance.

As has been repeatedly said, if our institutions would endeavor to use a common method in compiling and publishing those statistics, those figures would become increasingly valuable for all comparative purposes. It is therefore hoped that an ever increasing number of hospitals will adopt the methods that have previously been adopted as the recommendations of the association and which

have been discussed in more detail and emphasized in this report.

It is essential, in order to clearly understand the recommendations made, that the first report be at hand and available for ready reference, together with this the fourth report, when making a detailed study of this subject.

It is the committee's hope that both of these reports will be published in one bulletin by the association, and that the record forms suggested will also be available to the members of the association.

Accurate records are essential, if the executive is to know that his institution is giving the maximum of service for the money expended and if he is to render a true account of his work to those interested in the institution. This is as important in the smallest as well as in the largest hospital.

The funds expended in keeping accounts and records, may at times seem out of proportion to the results obtained, but it is believed that the system suggested in the report, properly adjusted to the individual hospital will always justify its cost.

The committee invites comment and criticism that will tend to improve further the recommendations it has made and that will aid in raising the present status of hospital statistics.

COPIES OF PLEDGE AND CREED  
DISTRIBUTED

Unanimous approval was accorded to MY PLEDGE AND CREED, copies of which were distributed at the conference. It was generally conceded to express the true spirit with which those who are administering to the sick should look upon their individual parts in that service.

After all, a hospital is not buildings, plant, equipment and the like, but an organization of men and women, trustees, administrators, physicians, nurses, technicians, artisans and the like. Each has his particular task but all work to the one end of adequately and efficiently serving the sick in the hospital.

No work to that end is undignified or menial. All these will go about their work with greater zeal, perhaps, if they from time to time recall the inspirational words of MY PLEDGE AND CREED.

The *Daily Bulletin* which for the past several years has become a tradition of the conference, was issued each morning of the Buffalo conference. It gave the program for each day and official announcements, notices of special meetings and committee appointments. Each issue contained the registration of the previous day.

The Nurses' Association of New York State had a reception room in the armory open all day for the guests and delegates to the conference, where tea was served every day from three to five o'clock.

\* Abstract of the report of the committee on records and accounting submitted to the twenty-sixth conference of the association, Buffalo, N. Y., Oct. 6-10, 1924, by A. C. Bachmeyer, M. D., chairman.



# The MODERN HOSPITAL

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## SERVICE IDEALS INSPIRED BY THE BUFFALO CONFERENCE

THOSE of us who are in regular attendance at the annual conferences of the American Hospital Association sometimes become so absorbed in all that takes place that we lose sight of their real significance. In the same way, in the rush of our commonplace daily tasks, we overlook the tremendous value of the contribution which our hospitals are making to life in the United States and Canada.

A man who this year made his first A. H. A. conference pilgrimage and participated in the proceedings, commented upon some phases of the gathering in a way that is well worth both our thought and appreciation. Familiar as he is with large national conventions of various bodies, this observer was amazed at the fine humanitarian and spiritual atmosphere which pervaded the conference. The banquet on Tuesday evening, he remarked, might well have been that of a great religious body, for the high tone of the addresses, the spiritual passion for service to the physically broken by accident and disease, and the lofty ideals set forth as an accompaniment of that service, glowed with that devotion and fervor prompted by religion. This zeal, linked with the tremendous magnitude of the mission of the hospital, created a feeling of wonder and amazement at the prevailing ignorance in America concerning the ministry whose activities were crystallized in the papers, discussions and exposition. As the various phases of hospital service unfolded before him, he caught, as never before, the fine spirit which actuates practically all who make possible the day's work in our hospitals, large and small.

The cordiality of those present made him realize what a camaraderie a common task of humanitarian service gives to those who toil unselfishly for the alleviation of pain, the repairing of broken bodies and the prolonging of life. It was as a large family, home for a conference together, each enough interested in the other's task to be a good listener and to rejoice in any new achievement the brain and hand of another had made possible.

That men and women will come together to give freely of their knowledge, experience and discoveries, is no small thing. Yet to our visitor it seemed to be all a part of an enthusiasm for giving the best material equipment and the beneficent results accruing to that helpless individual, the patient.

In an English novel in vogue twenty years ago, "No. 5 John Street," the drab, diseased life of

the rubber workers was contrasted with the social life depicted in a ball given by the owner of the rubber mill. After commenting on the toil of the consumptive rubber workers who made the ball possible, the author causes one of his characters to remark, "There must be a back kitchen somewhere in Heaven."

With all the excellent organization which made this convention a smooth running one, the same thought pushed its way into consciousness. No such program and exposition could have sprung into being without great toil. And remarkable as it may seem, our observer declared it the first great convention he had ever attended, religious or secular, where the presiding officer of the convention was big enough to give credit by name to those who in all organizations carry the burden of the day, those men and women who occupy office positions.

It was good to have among us one who, out of years of experience, is able and willing to appraise us afresh. That he should bemoan the fact that so few know either the kind of people who make up our hospital executives or their aims and achievements, is a feeling shared by many of us. The impression made upon our visitor, who confesses that he is a bit "hard-boiled" as far as conventions are concerned, is evidence that our Buffalo convention is but a glimpse at the story which the whole world should know.

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### ARE YOU A DAM?

A HOSPITAL superintendent recently told this story:

"When I took charge of our hospital, I announced the following policy. 'It is the aim of this institution to give to its patients the best professional care, to do everything which will return the patient to health with the utmost expedition and to do these things in the spirit of kindly, whole-hearted personal service.'

"My objective was the abolition of cold impersonal care and the substitution of real service which considers the patient as another human being subject to the same weaknesses, likes, dislikes and whims as are common to all mankind but magnified by sickness and therefore to be met with understanding tolerance. The bulk of the medical staff got the idea—I think they rather welcomed it—and they tried to carry it into effect. It was not long, however, before I found that the policy did not reach the bedside, as somewhere along the line something was damming it back.

"I couldn't understand it. We had a splendid

lot of nurses, our technicians and orderlies were unusually competent. There was no suspicion of downright disloyalty yet the facts remained that the policy wasn't taking the hurdles. I wondered if the fault lay in my presentation of the policy so I tried various methods of promulgating it but it didn't get over. I was badly discouraged.

"Finally, quite by accident I picked up a little clue. It lead me to the place I had least suspected, to the office of the superintendent of nurses. To my surprise I found that my pet policy had been presented to the nurses as one of the new superintendent's theories! Here was a highly competent woman with a single sneering phrase absolutely defeating a basic policy. Pursuing the question further I found that practically all of my orders affecting the nursing staff had been entirely divested of their spirit enroute. Searching for the underlying motive I found that the nurses had been indoctrinated with the idea that there existed an impassable antagonism between doctors and nurses and that the latter always got the worst of any controversy.

"I had a long private talk with my superintendent of nurses and explained to her the exact effect of what she had been doing. We had a long discussion over true loyalty and I impressed her with the thought that the acid test of true loyalty is the manner in which an official transmits the orders of his superiors to his subordinates. It is my belief that this thought had never been presented to her before. At the same time, I attacked the superstition that doctors are the natural enemies of nurses.

"That was all that was needed. The morale of the hospital rose almost at once and our hospital is now imbued with the spirit of genuine service. I doubt if this is an isolated instance. I doubt if the fault is always in the nursing staff, it might quite as well lie in the medical staff or among the dietitians or any other group in the hospital. The point is that when a policy fails to get across some person or group of persons is acting as a dam. This may be intentional. Usually it is not and arises solely from a lack of understanding of true loyalty. The average person never analyses loyalty, that perpendicular virtue which should run equally up and down, a word whose etymology, **loy**, **law**, **alty**, higher, the higher law, gives a picture of its real meaning. Truly it is the higher law, transcending rules, regulations and statutes and imposing on superiors and subordinates alike the obligation of faithful adherence. Every officer and employee of our hospital is now instructed in its true definition and application, a course of action which, I believe, should be universal."

## THE END-RESULTS OF UNFORTUNATE PRESS NOTICES

“OPERATED upon at Blank Hospital, Edwin Town, 17, son of Mr. and Mrs. Perry Town, rear 244 B— Street died yesterday.”

“The body of Quentin Moor, 57, coal miner, who died yesterday at Blank Hospital from effects of an operation was sent to his home, Mine City, for funeral and burial.”

“Following an operation at Blank Hospital, Mrs. Edgar Dean, 41, wife of Will Dean, 386 Ohio Avenue, died.”

These three notices appear in the obituary column of a single issue of a daily newspaper having a wide circulation in one of our most populous states. Similarly worded obituary notices appear daily in this paper and doubtless in many another.

What impressions of hospitals thousands gain from the reading of such unfortunately worded announcements is not difficult to imagine. They are eminently unfair to the hospital and to the surgeons who practice in them. The strong probability is that in most of these cases the patients die not from, but in spite of, the operation.

Undoubtedly notices such as these induce an immeasurable amount of fear and deter many from taking advantage of the facilities hospitals offer, until it is too late. Hospital authorities owe it to their communities to see that misleading notices such as these are eliminated from their local newspapers.

The newspapers are not to be blamed too harshly for printing notices thus unfortunately worded. They are probably not thoroughly informed of the functions of the hospital and of the circumstances surrounding the death of these patients. To us, the appearance of notices thus worded is a striking illustration of the failure of hospital superintendents to give their hospital and the things that occur in them suitable publicity. Were the newspaper reporters shown through the institution and acquainted with its facilities, its purpose and its activities, notices such as these would soon disappear from the columns of the daily press.

## OUR PRIZE CONTEST

THE date for registering entrants in our prize essay competition on “The Interrelationships of Hospital and Community,” is now past and the list of contestants shows the names of over eighty hospital, public health and social workers and others who will submit essays on this topic of far-reaching interest.

The prospective participants are drawn from

widely scattered and diversified communities in the United States; there are also several entries from Canada and one from England. This gives promise of a series of articles covering health and hospital plans that are adapted to varied community needs, and should bring out important points of interrelationship, and emphasize the fact that in unity is strength and that a single agent cannot stand alone.

It is hoped to secure, through these essays, an experience record of the many types of successful interrelationships that have been worked out between hospital personnel and community agents, and that very practical benefit will thereby accrue to the field.

The committee of award consists of three outstanding leaders in the hospital and public health field—Dr. Haven Emerson, professor of public health administration, Columbia University, New York, N. Y.; Mr. Michael M. Davis, Jr., executive secretary, Committee on Dispensary Development, New York, N. Y., and Dr. Willard C. Rappleye, superintendent, New Haven Hospital, New Haven, Conn., and professor of hospital administration, Yale University, New Haven. The committee will meet shortly after the first of November, the final date for receiving contributions, to consider the essays and award the prizes.

## AGAIN NOMINATIONS FROM THE FLOOR

FOR a second time since the constitutional amendment was passed, giving the right to nominate officers from the floor and to elect by ballot, the American Hospital Association at its recent conference at Buffalo disregarded the recommendations of the nominating committee by nominating a president-elect from the floor and electing him by a substantial majority.

In so doing the association maintained one of its lifelong traditions in showing its appreciation of the valuable service which the president-elect has rendered the association by conferring on him the highest honor within its power. To all who have contributed materially to the growth and development of the association, the privilege of maintaining a precedent of this kind must have been a great source of satisfaction.

The success of an association of the size of the American Hospital Association can safely be left in the hands of the entire membership without any reflection on the action of the nominating committee which has not the time or the means of making a canvass that would more nearly express the sentiment of so large a number as the voting members of the associations.

## AN ONLOOKER'S IMPRESSIONS OF THE BUFFALO CONFERENCE

THE Buffalo conference of the American Hospital Association was to the writer a premier performance, the enactment of a new drama filled with color and light and all that goes into the making and the operation of that human institution which touches most intimately the heart and mind and body of man—the hospital.

The very air seemed to breathe a welcome; the Jehus of the steering-wheel, the burly policeman, the expectant bellhops seemed glad to greet the stranger; Dr. Goodale and his committee had written "welcome" on the doormat in a bold chirography.

The battlemented armory clothed with spacious grimness was approached by an incline reminiscent of the chateaus of Louis IX.

Within to the left an information booth was functioning. It was remarkable in that it gave information, accurately, courteously, and humanly. To the right, was the registration office, crowded by delegates. There was no noise, no confusion, no impotent hurrying. The registrants seemed to be the people who know just what they wanted to do and how they were going to do it. The registrars seemed to know their side of the question well. The result was (to use the Navy's slogan) speed, dash and accuracy.

The half-million dollar exhibit, the largest that the world has ever seen, was a credit alike to those who conceived it and to the exhibitors who made it possible. It was practical to the last degree; usefulness, real service, durability, ingenuity which amounted to genius, and genuine beauty of design were the outstanding features. The demonstrators were kindly courtesy itself. There was no ballyhoo; only in one booth was the order book in evidence with pencil poised; visitors were received with the modesty and decorum of the drawing room.

There were plenty of chairs which added to the visitor's comfort in the careful study of foods, bedding, furniture, surgical instruments, illuminating devices, x-ray equipment, messgear, kitchen installations, surgical dressings, door-checks, books, charts, models, physiotherapy machines and the myriad of other exhibits required time, effort and the expenditure of much physical energy. It was an honest presentation of the best of everything which enters into the formula of real service to the patient.

It was interesting to watch the crowd pass slowly up and down the long aisles of snow-white booths trimmed just enough with the fresh green of trailing ivy. These people were earnest seekers; the centuries old uniforms of nuns, black and grey and brown, with contrasting white, doctors who looked like business men and superintendents of nurses who resembled care-free matrons, dietitians, who might have been mistaken for college girls, manufacturers who inspired the title of pastor and some who did not, all were there and many types besides. But, they all appeared serious, hard-headed, practical people whose feet took hold on solid earth. Some of them apparently took life very seriously; most of them seemed to have measured the worth of human existence accurately and to have devoted themselves whole-heartedly to the acquisition

of those riches which come from human experience; all seemed to be people who play too little. There was a noticeable absence of women who had committed "bobbery."

The meetings of the sections were startling; formality was thrust into the background; there was a complete absence of "bunk"; there was a spirit of real democracy; the papers were largely conversational in type; they were without circumlocution and the discussions went into practical economics to the "nth" power. Generally there were few vacant seats, many of the younger members took careful notes; the pest who talks while other people are speaking was there, but not in epidemic proportions. In every meeting the spirit of personal service to the patient and obligation to the community was constantly stressed. It was apparent also that there is a growing realization of the public health duties of the hospital.

The evening meetings were less tense; the fatigue of the day was forgotten; there was more joviality witnessed in Mr. Test's Sambo story and the singing of the pre-Spanish War songs at the dinner under the leadership of a member who has been well named. Who will forget the airy badinage of some of the foreign delegates, the polished address of Dr. Goldwater, or the splendid and well-deserved tribute which Dr. MacEachern paid to Dr. Warner and his associates?

The international aspects of the meeting have a significance which is of great moment. The presence of delegates from Great Britain, New Zealand, and China indicates the spreading influence of the ideals of the association, ideals which make for that true civilization which brings peace between men and nations. The presence of our Canadian members evidenced the ability of two nations to dwell together in amity.

This was emphasized by the consolidated hymn which was sung at the dinner.

The entire spirit of the Buffalo conference was crystallized in "My Pledge and Creed." It was seen everywhere. Its one hundred words were exemplified over and over again by those who attended the meetings, because these words represent the animating influence of the ideals which perpetuate and make a part of the daily life of hospital workers the soul of the Good Samaritan.

It was a great meeting; a stimulus for the backward, an education for the less informed, an inspiration to the worker for the physical salvation of mankind, and a satisfaction and achievement for those who made it possible.

### ILLINOIS TUBERCULOSIS ASSOCIATION MEETS AT DECATUR

The annual meeting of the Illinois Tuberculosis Association was held at Decatur, October 27 and 28. Some of the features of the meeting were the surgical clinics held at the Decatur and Macon County Hospital, and the technic of artificial pneumothorax which was demonstrated at the Macon County Tuberculosis Sanatorium.



Dr. A. C. Bachmeyer, the Buffalo conference choice for president-elect.

## TWENTY-SIXTH CONFERENCE SUPERSEDES ALL FORMER MEETINGS OF A. H. A.

THE martial notes of a bugle sounded the opening of the twenty-sixth annual conference of the American Hospital Association at 2:30 Monday afternoon, October 6, at the 106th Field Artillery Armory, Buffalo, N. Y. The pompous bugle call broke the din of greetings of hundreds of representatives from the American hospital field who were registering at the armory, and announced the two opening section meetings of the conference, the small hospital, and the out-patient sections.

That the small hospital section deserved the front rank of section meetings was evidenced by its great popularity, which placed seats in the armory theater at a premium and compelled many of the eager small hospital enthusiasts to stand during the entire program. The meeting was called to order by Miss Charlotte Jane Garrison, superintendent, Polk County Public Hospital, Des Moines, Iowa, who presided over the section.

The opening paper of the session, on the subject of "Tuberculosis and the Small Hospital," was presented by Mr. T. B. Kidner, institutional secretary, National Tuberculosis Association, New York, N. Y., who outlined a comprehensive study for the handling of tuberculosis by the general hospital, touching upon the many aspects of the problem. Mr. Kidner's paper appears in full on page 422 of this issue. The discussion following this paper was opened by Dr. Walter H. Conley, general medical superintendent, department of public welfare, New York, N. Y., who was strong in his defense of the county hospital system of caring for tuberculous patients as opposed to general hospital care. Dr. Conley directed attention to the county hospital system of caring for the tuberculous now in practical operation in the state of New York, as the most feasible solution of the problem. He objected to the plan presented by Mr. Kidner as being impracticable for the small hospital of from twenty-five to fifty beds, because the majority of such hospitals can rarely afford to set aside one or more beds and the necessary facilities for the satisfactory treatment of tuberculosis.

The problem was also discussed by Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati, Ohio, who was in hearty accord with Mr. Kidner's idea, which, he declared, was a real contribution to the

problem of handling the tuberculous patient. Dr. Bachmeyer agreed that tuberculosis can and should be satisfactorily diagnosed and temporarily treated by the small general hospital. He showed the real opportunity which awaits the general hospital in this direction—a thing which will help to overcome the harmful results of permitting patients to be many months on the waiting lists of county hospitals. During the period of waiting many patients develop complications which are not properly

attended to in many of the specialized and county hospitals. Dr. Bachmeyer also pointed out the benefit to the medical and nursing staffs of setting aside a room or two for tuberculous patients where the disease may be studied and treated. However, he does not agree that it is wise for the general hospital to attempt to provide highly specialized facilities, such as the quartz lamp and the carbon arc lamp, which are required for long treatment of cases, but believes that the general hospital should diagnose and care for the disease in its early stages.

The other paper of the session was on the subject of "One Solution for Bringing Metropolitan Services to Small Country Communities," read by Dr. Denver M. Vickers, resident surgeon, Mary McClellan Hospital, Cambridge, N. Y. Dr. Vickers analyzed the problem from the standpoint of his own institution and showed how through an organization of the staff into three groups, which include the local nearby practicing physicians, the consulting or visiting staff, and the

resident staff composed of recent graduates, the small hospital can avail itself of highly qualified physicians and surgeons. Dr. Vickers' paper will appear in full in the December issue of THE MODERN HOSPITAL.

This paper was discussed by Dr. Don K. Hutchens, Rochester, N. Y., who, from first-hand knowledge, attested the success of the plan of staff organization and the efficiency of the work carried on at the Mary McClellan Hospital, and emphasized that a similar staff arrangement in other hospitals would be necessary to make metropolitan services available to the small hospital. Such an organization entails difficulties in many communities, but where it can possibly be arranged is advantageous to the staff in presenting opportunity to resident members to develop themselves after internship



Dr. Malcolm T. MacEachern who, upon retiring from the presidency of A. H. A., presented flags to the two territories ranking highest in the membership campaign.

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Mr. E. S. Gilmore who will wield the A. H. A. gavel during 1925.

in metropolitan hospitals.

The remainder of the session was devoted to a roundtable discussion conducted by Miss G. Gruver, superintendent Davis Hospital, Pine Bluff, Ark. The subject of securing probationers for nurse training schools was discussed by Mrs. B. M. Hopper, superintendent of nurses, Jackson Infirmary, Miss., who offered a number of suggestions, such as good magazine advertising, having nurses take part in public health work, forming a Y. W. C. A. club of nurses for various training schools in the same city, as valuable means of creating a favorable impression of the school, thereby attracting desirable probationers. She stressed the necessity of broadening the interests of the student beyond the walls of the training school.

The topic of educational standards for nurses was discussed by Miss Elizabeth Greener, principal, school of nursing, Mt. Sinai Hospital, New York, N. Y., who strongly

urged well-directed supervision and follow-up work by state boards of examiners. She strongly emphasizes the responsibility of the board of directors in securing funds to keep the small training school up to the standards laid down by the state with regard to the curriculum and facilities for providing adequate training.

#### Advocates Training School Affiliation

Training school affiliation was discussed by Miss Alice S. Gilman, secretary, state board of examiners, Albany, N. Y., who showed the inability of the small hospitals to provide adequate practical nurse training in other branches than surgery. The prevalence of this condition necessitates the affiliation of small schools with those connected with larger hospitals where adequate practical work is maintained in the branches of medicine, pediatrics and nutrition.

The subject of hospital purchasing was discussed by Mr. E. E. King, superintendent, Baptist Hospital, Little Rock, Ark., who summarized the keynotes of small hospital purchasing in three suggestions, namely, common sense, knowledge of the hospital's details of demand and supply of products, and tact in dealing with salesmen. Mr. King brought out that the trouble with many small hospitals is that they buy too much and speculate on the market.

The subject of laboratory fees was handled by Mrs. H. M. F. Bowman, Women's College Hospital, Toronto, Ont., who pointed out the difficulty in the way of presenting any general conclusions for setting laboratory fees because of the differences in economic upkeep between the larger and smaller laboratories. In general, she stated, fees are higher in hospitals where the laboratory is large and has extensive equipment.

The making and filing of case records were the subjects discussed by Miss Margaret Rogers, superintendent, Lafayette Home Hospital, Lafayette, Ind., who summa-

rized the essentials of making and keeping adequate case records in three groups, namely, the necessity for having (1) adequate materials for recording, such as good paper and proper working facilities; (2) routine and intelligent recording; (3) adequate filing and reference facilities so that records are readily accessible. Miss Rogers advised that every hospital of fifty beds should have one full-time record clerk.

#### Out-Patient Section Discusses Report

Simultaneous with the meeting of the small hospital section was that of the out-patient section, held in the ballroom of the Armory. Following the opening remarks of the chairman, Frank E. Wing, director, Boston Dispensary, Boston, Mass., Dr. Alec N. Thomson, medical secretary, Committee on Dispensary Development, New York, N. Y., and chairman of the committee on out-patient work, spoke on the report of that committee, which was distributed in printed form, and explained that it was the same as that presented at the 1922 and 1923 conferences but for certain minor changes and an addition relating to staff organization which brings to the front four questions, namely: Who shall appoint the staff? Who shall nominate the staff? For how long should a physician be appointed to the staff of the institution? What should be the minimum requirements for appointment?

The medical profession in its relation to the dispensary was discussed from two angles in papers contributed by Dr. John E. Jennings, attending surgeon, Brooklyn Hospital, Brooklyn, N. Y., and Dr. A. K. Paine, surgeon-in-chief, department of diseases of women, Boston Dispensary, Boston, Mass.

In speaking of the opportunity of the medical profession in dispensary work from the point of view of medical education and graduate teaching, Dr. Jennings spoke of the struggle for self-improvement which is noticeable in the medical group as witnessed by the intensive work being done in post-graduate schools, medical colleges and teaching hospitals; the frequent meetings of local medical societies and the practice of visiting fellow physicians; and the operative and diagnostic clinics held in our hospitals.

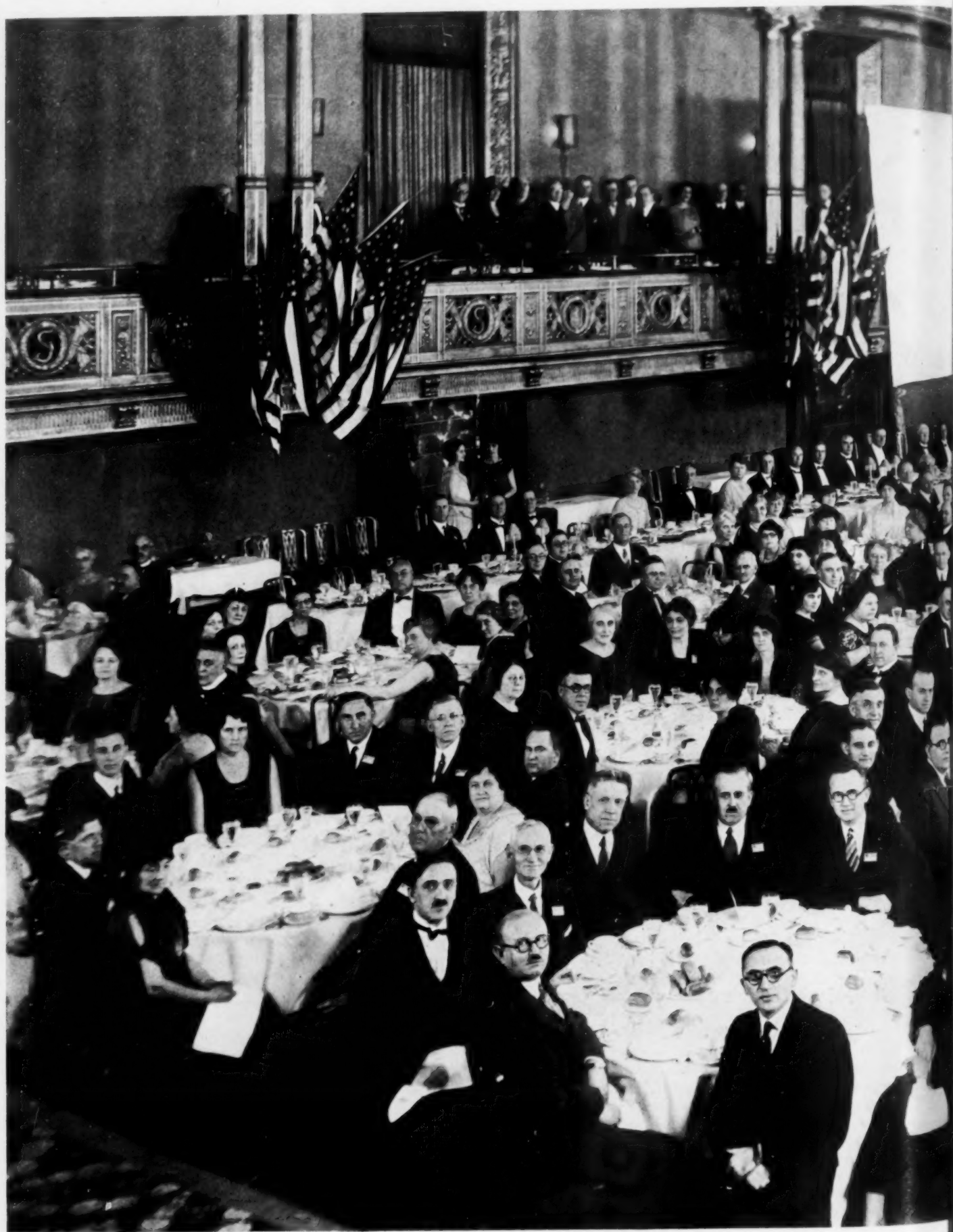
The dispensary, Dr. Jennings emphasized, is one of the main avenues to the knowledge which the young doctor is demanding; there is his opportunity and upon what he is able to learn and apply there depends, in great measure, the success of his career.

"I am certain," said Dr. Jennings, "that if definite graded courses of service in out-patient departments were given so that in a year or two a graduate student could go the rounds of the more important clinics and obtain a diploma or even a degree, the



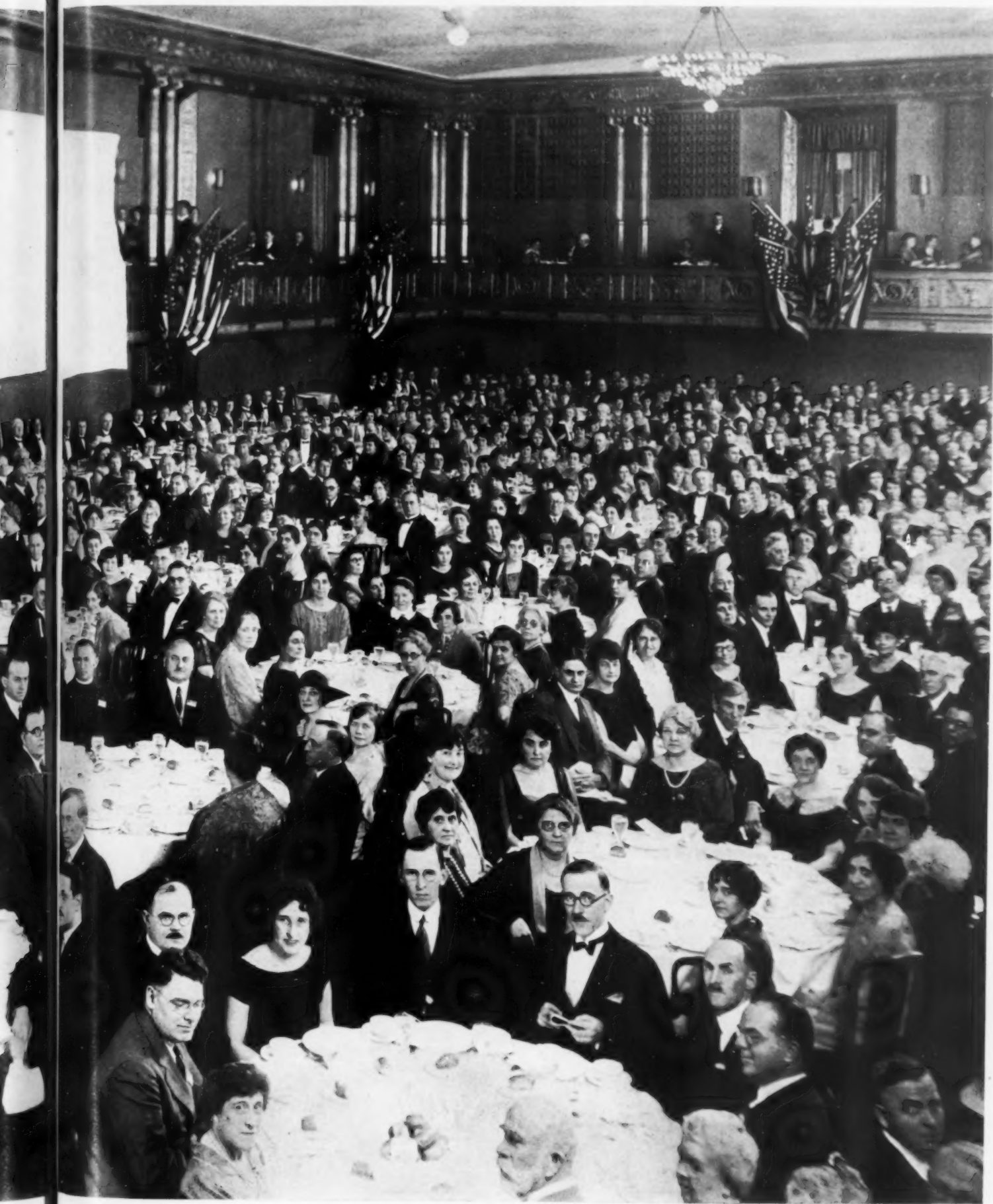
Mr. J. Courtenay Buchanan, representative from the British Hospitals Association, one of the distinguished foreign guests at the Buffalo conference.

## FLASH LIGHT TAKEN AT ANNUAL BANQUET



Above is the camera's impression of the big social event of the conference, the banquet held in the ballroom of the Statler Hotel, Tuesday evening, October

## SESSION OF THE BUFFALO CONFERENCE



Evening, October 7. In the background to the left is the banquet table where were seated the officers, speakers and guests of the association.

opportunity would be welcomed everywhere."

The speaker further pointed out that there exist in great city hospitals half-developed, uncoordinated graduate schools which are doing much of the work of training our specialists in medicine and surgery, and suggested a plan for an out-patient department in which stated terms of service would be arranged and men admitted upon establishing their fitness; where suitable theoretical instruction would be given, supplementing the practical training of the clinics, and where examinations would be given testing the candidate for a proper certificate.

Dr. Paine took up the subject of the responsibility of the medical profession from the point of view of the importance of out-patient work and the necessity of adequate staff organization. He made plain that it is often when a man first comes to the out-patient department, rather than when he enters the hospital as a subject for treatment, that he stands in need of the most skilled supervision, for it is in their initial stages that many medical and surgical conditions present the most difficult diagnostic problems and it is also at this point that such conditions lend themselves readily to skillful management. In view of these facts, Dr. Paine feels that the fine buildings, the modern equipment, the efficient management and the highly qualified staff of a modern hospital represent a combination which, if directed toward the patient in the early stages of his disease, would pay big dividends to the cause of preventive medicine.

### Good Out-Patient Staff Needed

Too often, Dr. Paine emphasized, the out-patient department is inadequately housed and too often, also, poorly staffed, a fact still more to be deplored, since the important thing is not where the patient makes his first medical contact but with whom it is made. In order, then, to attract the best element of the medical profession to the out-patient department, he believes that we must furnish there as generously as in the hospital the material equipment necessary for the physician's best efforts. The following four points summarize Dr. Paine's consideration of the problem of adequate staffing of dispensaries and out-patient departments: (1) Adequate technical equipment is a condition precedent; (2) the senior staff in the hospital should have definite out-patient department responsibilities; (3) the relative value of out-patient and certain types of in-patient service should be seriously considered when in a given institution lack of funds is the explanation of inadequate out-patient development; (4) the dispensary should develop a systematic method of making staff appointments, a method based on a temporary appointment open to any properly trained physician who cares to apply.

### Better Recognition of Out-Patient Work

In discussing Dr. Jennings' paper, Dr. A. B. Denison, superintendent, Lakeside Hospital, Cleveland, Ohio, said that the dispensary is the ideal place for a man to start the practice of medicine itself after he has had the perspective given him by the mass of scientific data which is presented to him in school. In the dispensary, too, said Dr. Denison, he will get necessary personal contact with medical men of experience. He also favors recognition of out-patient work in the form of a certificate.

The discussion of the two papers was continued by Dr. John B. Spelman, superintendent, Touro Infirmary, New Orleans, La.; Calvin H. Goddard, director, Cornell University Medical Clinic, New York, N. Y.; Dr. N. P.

Colwell, Council on Medical Education of the American Medical Association, Chicago, Ill.

### Opens with Anglo-American Anthem

Because of the international character of the conference it was altogether fitting that the first general session should be opened with the singing of the Anglo-American hymn. The invocation, which followed, was pronounced by the Reverend Cameron J. Davis, rector Trinity Protestant Episcopal Church, Buffalo, who took occasion to conclude his prayer with the recitation of "My Pledge and Creed."

Addresses of welcome on behalf of the city of Buffalo as a whole and on behalf of the hospitals of Buffalo, were made by the Hon. Frank X. Schwab, mayor of Buffalo, and by Dr. Renwick R. Ross, superintendent, Buffalo General Hospital. To these addresses Mr. Daniel D. Test, superintendent, Pennsylvania Hospital, Pennsylvania, Pa., responded in his usual happy vein. He took occasion to emphasize the international character of the conference and its influence in creating good fellowship among the countries participating.

Mr. B. A. Watson, chairman, Hospital Exhibitors' Association, spoke briefly on the exposition of equipment and supplies.

Following the introduction of representatives from various foreign countries Dr. Malcolm T. MacEachern delivered his presidential address. (For an abstract of this address see page 391) Instead of reading his address in full Dr. MacEachern summarized it in a brief informal talk, illustrated with stereopticon slides.

### Favors Adoption of "My Pledge and Creed"

At the conclusion of the president's address, the meeting, on the motion of Mr. Robert Jolly, superintendent, Baptist Hospital, Houston, Texas, seconded by Mr. Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, Ill., went on record as favoring the adoption by the American Hospital Association of "My Pledge and Creed" as thrown on the screen during Dr. MacEachern's address.

Reports from the trustees, the treasurer and the membership committee followed the president's address. The report of the board of trustees touched upon the adoption of a standard system of medical nomenclature for hospitals, the association's cooperation with the federal bureau of standards in simplifying hospital equipment, the inauguration of a general membership campaign, the establishment of an honor service roll for trustees, the provision of a suitable building for the headquarters of the association, the inauguration of special studies regarding out-patient clinic fees, methods of financing hospitals, the transfer to the association of National Hospital Day, the appointment of special committees on interns and on cooperation between hospitals and health departments.

On the motion of Dr. A. C. Bachmeyer, a resolution was adopted expressing the association's appreciation of the work of Dr. A. R. Warner, executive secretary, and its hope for his uninterrupted and speedy recovery to health.

Before the formal papers of the evening were read the delegates had the pleasure of listening to three delightful selections by the Orpheus Choir of Buffalo, of which Mr. Lund is the director.

Following this brief musical program Mr. John A. Lapp, director, department of social action, National Catholic Welfare Council, Chicago, Ill., read a paper on "The Hospitals and the Workmen's Compensation Laws." (See page 413.)

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Mr. Lapp was followed by Mr. Ralph W. Keeler, counsellor in publicity, Board of Hospitals and Homes of the Methodist Episcopal Church, New York, N. Y. Mr. Keeler's paper had to do with hospital publicity and will appear in full in our December issue.

The session concluded with an address by Mr. Robert Jolly, superintendent, Baptist Hospital, Houston, Texas, on "Our Responsibility to the American Hospital Association." In the course of his address, Mr. Jolly called on the members of the American Hospital Association to help the association in the following ways: by enlisting the unenlisted; by forming smaller units; by interesting hospital trustees in the association; by giving the association publicity and by definite efforts to make the A. H. A. take its place and play its part in the hospital life of North America.

Tuesday morning's general session was given over to a consideration of the reports of the special committees and to three papers. Since all the reports appeared in printed form, they were not brought up for formal consideration, but referred to specific section meetings, as indicated on the general program. Time was allotted, however, for the chairmen of these committees to come before the assembly and offer any suggestion or remarks which they desired.

The report of the committee on the training of hospital executives under the chairmanship of Dr. F. A. Washburn, chairman, pointed out the need of challenging the best trained workers in the health field by encouraging research work in the hospital field and by having qualified students placed in some of the outstanding progressive hospitals in the country where they might work at these problems. The committee recommended that an effort be made to establish several fellowships in hospital administration under the National Research Council or other auspices, to finance qualified individuals to work on the problems of hospital administration under such conditions of freedom from routine work as will permit of productivity and training.

The report of the legislative committee summarized by Dr. E. T. Olsen, superintendent, Englewood Hospital, Chicago, Ill., presented a number of constructive criticisms of the abundance of state legislation concerning hospitals that is unnecessary and is embarrassing to hospitals, and recommended that a close and early scrutiny of all proposed legislation affecting hospitals, local, state and national, followed by vigorous and organized support of such measures as are beneficial and a correspondingly active opposition to all measures which are detrimental. The committee pointed out that the accomplishment of this purpose requires the assumption by some hospital organization or by some individual who is familiar with legislative procedure of the burden of watching legislation in each state; the full cooperation of the board of trustees and the staff of every hospital in each state, and the

establishment of a central clearing house which can advise, collect and disseminate information to the various state organizations.

The committee on cancer control headed by Dr. Ernst P. Boas, medical director, Montefiore Hospital for Chronic Diseases, New York, N. Y., reported that, although hospitals can contribute little in the direct control of cancer they can aid in the indirect control in two ways, first by assisting the American Society for the Control of Cancer, and by offering the most complete facilities for the care of cancer patients.

Hospitals can aid in the way of educational propaganda regarding the disease and by establishing free cancer diagnosis clinics. Hospitals can do much in the improvement of care of cancer patients by periodically discussing and determining the best methods of treatment and then proceeding to install proper x-ray and radium therapy equipment. The committee also brought out what can be done in the way of more careful and systematic follow-up of patients and recommended that hospitals should cooperate in a survey of local hospital conditions to provide proper care for the sufferers. The establishment of special cancer hospitals in large centers of population was also encouraged.

The report of the committee on the relation of governmental bureaus and departments to hospitals headed by Mr. Clarence E. Ford, was confined to a summary of the conclusions in respect to governmental supervision of hospitals. The committee pointed out the need for supervision of general hospitals by governmental agencies, and advocated that the state, through an appropriate department of its government, supervise hospitals in the way of inspecting them with reference to all aspects of plant and management, such as fire protection, food, care of patients and the enforcement of proper standards. In addition to this supervision, the committee also recommended that in each state there should be an appropriate department or bureau having supervision over all the hospitals of that state, both public and private, to promote the welfare of properly conducted hospitals and to protect the struggling institutions. In the states not having such a department, the hospitals should take the initiative in securing necessary legislation and appropriations to carry on this work.

On behalf of the committee, Mr. Clarence E. Ford, superintendent, division of medical charities, New York State Board of Charities, Albany, N. Y., announced that Dr. Warren L. Babcock, director, Grace Hospital, Detroit, Mich., a member of the committee, was not in agreement with the conclusions of the committee and did not wish to go on record as signing the report.

On behalf of the committee on cleaning Dr. C. W. Munger, superintendent, Grasslands Hospital, Vallhalla, N. Y., chairman, said that, whereas last year's report of



Five New Zealand guests at the Buffalo conference. (Left to right) Dr. J. S. Elliott, chairman, New Zealand Council of the British Medical Association, Wellington, and Mrs. Elliott; Mr. W. S. Downs, business manager, board of trustees, Olago Hospital, Dunedin, and Mrs. Downs; and Dr. Alec R. Falconer, superintendent, Dunedin Hospital, Dunedin, New Zealand.

the committee was of a preliminary nature, the committee had now been working eighteen months and felt that its present report provided the first definite method of procedure for cleaning technique in the hospital. He also called attention to the committee's suggestions with regard to the instructions of employees.

### Psychiatric Patients and the General Hospital

The first paper of the session was "The Relation and Responsibility of the General Hospital in the Care and Treatment of the Psychiatric Patient," presented by Dr. William C. Sandy, director, bureau of mental health, Harrisburgh, Pa. Dr. Sandy contrasted our present attitude toward the treatment of the psychiatric patient with that of a short time ago, when the belief was prevalent that all mental patients should be segregated and submitted to all manner of mechanical restraint. This unfortunate treatment of the mentally diseased, Dr. Sandy pointed out, was due to the lack of a study of psychiatry. Now that we are approaching the problem from the standpoint of psychiatry we are finding out that the old methods of segregating patients are unsatisfactory and that the general hospital has a definite role in the care of mental patients.

"Since the average recovery rate is 25 per cent of all the admissions," said Dr. Sandy, "satisfactory provision can be made at many general hospitals to care for this class of patient." He advocated the setting aside of wards for large dormitories, such as those at Allentown State Hospital, Allentown, Pa., where patients can be treated with advantage both to themselves and to the hospital. Dr. Sandy believes that the responsibility of the general hospital in the care of these patients is threefold. The hospital has a function to perform in the activities of prevention in the way of providing treatment in out-patient clinics for mental patients. General hospitals should afford temporary care of mental patients until commitment procedure by providing wards where patients may be observed and studied. He feels that general hospitals should feel it their duty to provide facilities for the long treatment of patients with physical ills who should not be submitted to the stigma of segregated care. This last responsibility calls for an adequate personnel, consisting of an experienced psychiatrist and resident psychiatrist where possible, and one or more graduate nurses from a mental hospital.

### Advantages of Psychiatric Care to Hospital

Dr. Sandy's paper was discussed by Dr. George F. Stephens, superintendent, Winnipeg General Hospital, Winnipeg, Man., who enumerated the advantages of general hospital care for psychiatric cases for a temporary period. He showed that general hospital care will alleviate the burden of overcrowded state institutions, because it will mean that many cases can be arrested before they reach the chronic stage, as statistics show that 65 per cent of psychiatric cases in the past five years have returned to their homes cured. Then, too, it should be recognized that medical service in general hospitals is, on the whole, better than at state institutions, and from the standpoint of training in medicine the temporary care of psychiatric cases has distinct advantages for the general hospital.

### Provision for Chronics by General Hospital

"The Relation and the Responsibility of the General Hospital in the Care and Treatment of the Incurable Pa-

tient," was the subject of a paper read by the Rev. H. L. Fritschel, superintendent, Milwaukee Hospital, Milwaukee, Wis. The paper emphasized the lack of provision for the care of hospital patients who annually leave the hospital unimproved and showed the expediency of providing facilities for this class of patient. Mr. Fritschel pointed out that there are only fifty-seven institutions for convalescents and chronic invalids in this country—an entirely inadequate provision for the constantly growing number of chronics. He believes that large general hospitals, instead of ignoring incurable cases, should try to provide nearby annexes for them for the payment of a reasonable sum of money. He advocates infirmaries in connection with the general hospitals under the supervision of skilled nurses and physicians. This, he thinks, should be done in addition to the provision of hospitals for chronic diseases where scientific study and treatment can be made of chronic ailments.

### Predicts Bright Future for Small Hospital

The concluding paper of the session was "The Future and the Small Hospital," read by Dr. B. W. Caldwell, superintendent, University of Iowa Hospital, Iowa City, Iowa, who traced the development of the small hospital from pioneer days, when it served as a refuge for rural communities, to the present day, when there are 3,000 small hospitals in this country serving sixty-one million people who are just as insistent in their demands for the best in medical service as are the people of metropolitan communities. Dr. Caldwell pointed with pride to the efficient work now being accomplished by many of these hospitals, which are constantly manifesting higher ideals of professional service as the result of the standardization work of the American College of Surgeons. Dr. Caldwell sees a much broader field for the small hospital of the future in providing competent care for rural patients, who are now filling metropolitan hospitals. He believes that as the small hospital improves it will not be difficult for them to have competent surgeons and to maintain the same standards as the larger hospitals, and that it is the duty of the large hospitals to protect the smaller ones, to help them to be wisely distributed and efficiently administered.

### Small Hospital Only First Line of Defense

Dr. Caldwell's paper was discussed by Dr. Paul W. Wiperman, superintendent, Decatur and Macon County Hospital, Decatur, Ill., who believes that the place of the small hospital is definitely that of a first line of defense, for the small hospital can never economically provide the same service as the larger endowed or community supported hospital. He sees its development in the future not as a self-sufficient unit but as an affiliated institution of the larger hospital. He pointed out the practicability of promoting centralization, and strongly advocated a system of inspection by the state to avoid the building of small hospitals where their existence is not warranted and where they eventually become a burden to the community.

### Intern, Accounting and Records Reports

The administration section on Tuesday afternoon was presided over by Dr. Ralph B. Seem, director, Albert Merritt Billings Hospital, Chicago, Ill., and was devoted to the discussion of the reports of the intern committee and the committee on accounting and records, both of

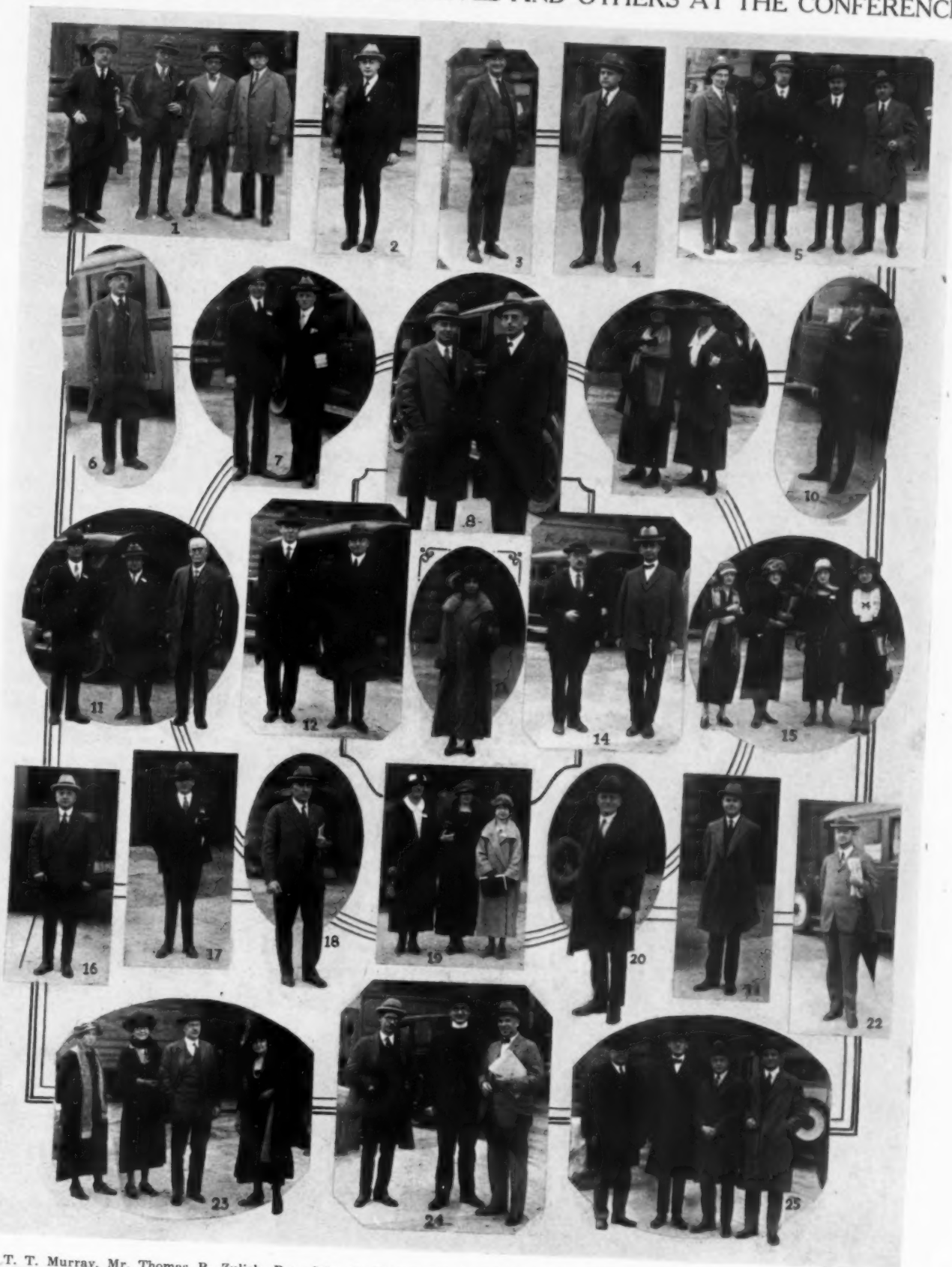
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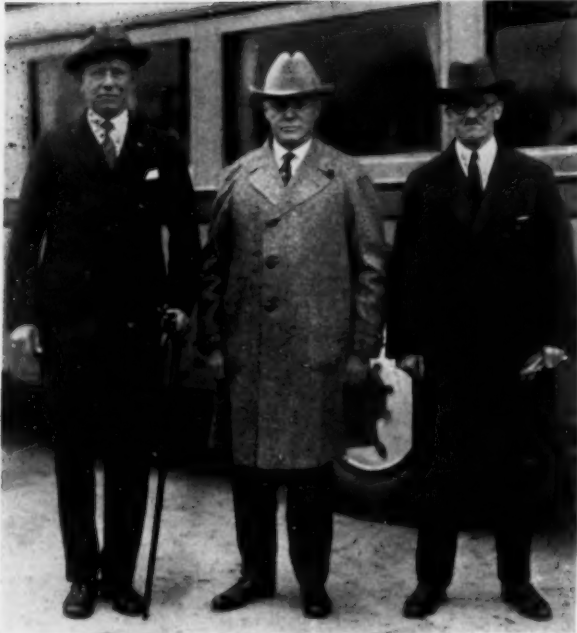
## THE MODERN HOSPITAL

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## GLIMPSES OF HOSPITAL EXECUTIVES AND OTHERS AT THE CONFERENCE



(1) Mr. T. T. Murray, Mr. Thomas R. Zulich, Rev. John G. Martin, Dr. Paul Keller; (2) Dr. W. P. Morrill; (3) Mr. T. F. Alexander; (4) Dr. Henry Hedden; (5) Dr. F. C. Bell, Dr. George F. Stephens, Dr. K. H. Van Norman, Dr. A. L. Gilday; (6) Mr. Edward F. Stevens; (7) Mr. E. I. Erickson, Dr. F. R. Nuzum; (8) Mr. B. W. Stewart, Dr. C. Hamlin Pelton; (9) Miss Adda Eldredge (left); (10) Dr. Walter E. List; (11) Dr. John Wharton, Mr. Paul H. Fesler, Dr. Charles A. Drew; (12) Dr. A. O. Fonkalsrud, Dr. Frank C. English; (13) Miss Mary E. Yager; (14) Dr. Alec N. Thomson, Mr. Clarence E. Ford; (15) Mrs. Genevieve N. Lechevet, Miss Holden M. Wyland, Miss Bess E. Wyland, Mrs. I. Craig-Anderson; (16) Dr. Walter Conley; (17) Mr. C. A. Lindblad; (18) Dr. D. L. Richardson; (19) Miss Marian Petersen, Miss Margaret Drew, Mrs. J. H. Martin; (20) Rev. H. L. Fritschel; (21) Mr. W. L. Graham; (22) Dr. M. J. Westervelt; (23) Miss L. Bennett, Mrs. S. Hansmann, Mr. Howard E. Bishop, Miss Frances Chappell; (24) Dr. S. L. O'Brien, Rev. J. M. Westdorp, Mr. S. G. Davidson; (25) Dr. C. S. Woods, Mr. C. S. Pitcher, Dr. F. M. Steele, Dr. L. A. Sexton.



Three of the men who administer university hospitals. From left to right: Dr. Winford H. Smith, director, Johns Hopkins Hospital, Baltimore, Md.; Dr. L. B. Baldwin, superintendent, University of Minnesota Hospital, Minneapolis, Minn., and Dr. Ralph B. Seem, director, Albert Merritt Billings Hospital, Chicago, Ill.

which were distributed in printed form.

Dr. Nathaniel W. Faxon, director, Strong Memorial Hospital, Rochester, N. Y., and chairman of the intern committee, was first called on to present the findings of his committee, which was appointed two years ago but issued no printed report last year. An abstract of the intern committee's report will be found on page 421 of this issue.

### Proper Time for Appointment of Interns

Discussion of the report was opened by Dr. Frederick C. Zappfe, medical secretary, Association of American Colleges, Chicago, Ill., who complimented the committee on the excellence of its report, which, he felt, treated every phase of the question of interns. Dr. Zappfe said that two years ago the question of the proper time for the appointment of interns came before the Association of American Colleges and that he had sent a letter to the dean of each of the seventy odd colleges in the association in order to gather opinions on this subject. The majority was in favor of the appointment being made not before the first of March in the fourth year of medical study. By that time, it was felt, that the senior work was well under way and the college was in a position to state whether or not the student would graduate. Dr. Zappfe felt that if this practice were followed the hospitals would get better interns, as a more satisfactory selection can be made from the senior than from the junior class.

With regard to the method of appointment, the best method of all, in Dr. Zappfe's opinion, is certification by the dean of the college. This gives the college some control over the intern and the college will see that the intern fulfills his agreement.

Dr. Zappfe also emphasized the point that if a hospital wants interns it must be willing to give them something in return; that is, it must do some teaching and,

if possible, some research work. If the American Hospital Association and the Association of American Colleges will get together they can regulate the matter of the intern, Dr. Zappfe believes, for the Association of American Colleges will try to get good material for hospitals if the American Hospital Association will see that some instruction is given the intern by the hospital staff.

### Should Offer More Attractive Internships

Further discussion, which centered around the proper time for the appointment of interns, was taken up by Dr. John A. Hornsby, superintendent, University Hospital, Charlottesville, Va., who was of the opinion that too early selection of the intern was a mistake from the standpoint of the medical school as well as from the standpoint of the student.

Other contributors to the discussion were Dr. J. B. Howland, superintendent, Peter Bent Brigham Hospital, Boston, Mass.; Mr. Richard P. Borden, trustee, Union Hospital, Fall River, Mass.; Mr. John S. McConnell, superintendent, Germantown Hospital, Philadelphia, Pa.; Dr. D. M. Morrill, director, Blodgett Memorial Hospital, Grand Rapids, Mich.; Mr. S. G. Davidson, superintendent, Butterworth Hospital, Grand Rapids, Mich., and Dr. A. K. Haywood, superintendent, Montreal General Hospital, Montreal, Que., who moved that the report be sent on to the committee on resolutions with the recommendation that the committee be kept in power for another year and be asked to communicate with the medical and surgical staffs of the hospitals in order that the hospital viewpoint may be obtained. The motion was seconded by Dr. W. P. Morrill, superintendent, Shreveport Charity Hospital, Shreveport, La., and carried.

Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati, Ohio, chairman of the committee on accounting and records, in presenting the committee's report for this year read the introduction and the conclusion of the report. An abstract of this report will be found on page 429 of this issue.

### Record Committee's Work Monumental

Dr. C. W. Munger, director, Grasslands Hospital, Valhalla, N. Y., opened the discussion on the report and expressed the association's indebtedness to the committee for their four years' work on this report which he characterized as monumental. He advocated the use of the report by hospitals in instituting new systems of records and suggested that they alter particular forms to suit their peculiar needs while keeping to the principles and main ideas put forward by the committee. Dr. Munger emphasized particularly the fact that delay in issuing monthly financial reports, census reports and especially medical record reports causes these reports to lose much of their value, and urged that hospitals issue such reports with the utmost promptness.

Dr. A. K. Haywood spoke in favor of uniform accounting systems for all hospitals, which would make it possible for one hospital to compare its financial report with that of another institution. He brought out that unless the same accounting system is used hospitals cannot with any benefit compare their annual reports. Dr. Haywood also suggested that if tact is used in asking department heads for their reports, and if it is explained why details are required, better cooperation will result along this line.

Miss Charlotte J. Garrison, superintendent, Polk County

Public Hospital, Des Moines, Iowa, said that while the report in its great comprehensiveness is perhaps more applicable to the large than to the small hospital, yet the superintendent of the small hospital could make use of the guiding principles in the report and adapt them to the needs of the small institution. She suggested that the committee might, in a later report, take up some of the points that have to be considered by administrators of special hospitals, such as children's or tuberculosis institutions.

Mr. Frederick B. Green, secretary, United Hospital Fund of New York, in speaking of the work done by the United Hospital Fund in collecting statistics on fifty-seven hospitals, said that in some cases no definite information could be obtained from the published report and gave some concrete examples of how well it pays hospitals to compile statistics that are accurate as well as to have proper accountings.

A motion was made from the floor and carried that this report be passed to the trustees with favorable recommendation.

Dr. Seem announced that the committee on relation of hospitals to public health activities was not prepared to submit a report at this time.

The dietetic section met in the ballroom of the armory Tuesday afternoon under the chairmanship of Miss Lulu G. Graves, supervising dietitian, Mount Sinai Hospital, New York, N. Y.

The meeting opened with a discussion of the report of the committees on foods and equipment for food service. (For abstract of this report see page 426.) The discussion was opened by Dr. C. G. Parnall, medical director, Rochester General Hospital, Rochester, N. Y. Following the discussion of the report Dr. George Baehr, Mount Sinai Hospital, New York, N. Y., read a paper on "The Economy of Modern Methods in Study and Treatment of Diabetes." This paper will be published in full in the December issue of *THE MODERN HOSPITAL*. A discussion of this paper was opened by Dr. John R. Williams, Highland Hospital, Rochester, N. Y.

Miss Kate Daum, Ph.D., Presbyterian Hospital, New York, N. Y., followed with a paper on "Unified Dietary Service of a Hospital." She stated that the relative value of diabetic treatments cannot be given as yet, because patients under dietotherapy do not respond under three or four years. However, the most logical treatment at present is this. Every case should be hospitalized as far as possible, because the disease can be put under control in much shorter time than in out-patient service, and the patient receives better instruction. Every case should receive insulin, because insulin shortens the time spent in the hospital, and has a possible curative effect.

She outlined the four-fold aim of the dietary department as follows:

(1) To give to all people concerned with the hospital, food which reflects the highest standard of nutrition; (2) to meet the psychological as well as physical needs of the people; (3) to contribute to nutrition, both normal and abnormal, and to scientific management of food; (4) to know how much the food service costs.

To do this, the hospital is organized into definite divisions:

(1) The routine feeding division attends to the purchasing, planning and preparing of the food for all people in the hospital, maintaining certain standards of cooking and service.

(2) The special diet division depends in point of size on the medical staff of the hospital, and is quite necessary to the proper training of pupil nurses.

(3) The educational department cares for the formal teaching of the pupil nurses, the entire training of pupil dietitians, diet instruction to the interns, the hospital patients and the clinic or dispensary patients, and a general effort to improve food habits among the hospital family.

(4) The research division must be carried on with the cooperation of the staff for nutrition problems and of the store and office for cost problems.

The concluding paper of the session was read by Dr. Thomas B. Downey, Mellon Institute of Industrial Research, University of Pittsburgh, Pittsburgh, Pa., who discussed "The Place of Edible Gelatin in General and Special Diets." This paper will also be published in full in our December issue.

### Guests Lend International Aspect

The twenty-sixth conference assumed an international aspect, Tuesday evening, October 7, when the banquet session was held in the ballroom of the Statler Hotel. From every standpoint this one social feature of the conference was generally conceded to be the most successful event of its kind that the association has ever held. Dr. Malcolm T. MacEachern presided over the banquet table where were seated the guests of honor from foreign countries, other guests, and a group of representative hospital administrators of the country.

Following the singing of the Anglo-American Anthem, and invocation by Rabbi Louis J. Kopald, Temple Beth Zion, Buffalo, N. Y., the four-course banquet was served during which time pipe organ selections as well as music from the harp and violin added festive notes to the assembly which tuned in on the old folk and popular songs, led by Mr. Robert Jolly, superintendent Baptist Hospital, Houston, Texas. The ensemble of mirthful songs was interrupted when Dr. MacEachern introduced the



A group of men who serve the hospital field in various capacities. From left to right: Mr. Charles F. Neergaard, consultant on hospital planning, New York, N. Y.; Dr. Paul W. Wipperman, superintendent, Decatur and Macon County Hospital, Decatur, Ill.; Mr. Michael M. Davis, Jr., Committee on Dispensary Development, New York, N. Y.; Mr. Joseph J. Weber, editor, *THE MODERN HOSPITAL*, Chicago, Ill.; Mr. L. H. Lewis, Crow, Lewis and Wick, architects, New York, N. Y.; Dr. C. W. Munger, director, Grasslands Hospital, Valhalla, N. Y.; and Dr. Joseph B. Howland, superintendent, Peter Bent Brigham Hospital, Boston, Mass.

guests present and proceeded with the evening's program.

Dr. MacEachern commented upon the success which has characterized the work of the various regional sections of the association in the general membership campaign and as a token of appreciation presented a flag to each of the two committee chairmen having the largest membership. Mr. Henry G. Yearick, superintendent, Homeopathic Hospital, Pittsburgh, Pa., chairman of the Pennsylvania region, which had the highest rank, was presented with a large American flag. The flag of Great Britain was presented to Dr. A. K. Haywood, superintendent, Montreal General Hospital, Montreal, Que., chairman of the region of Quebec and the Maritime Provinces.

The address of the evening, "Concerning Hospital Origins," was delivered by Dr. S. S. Goldwater, director, Mt. Sinai Hospital, New York, N. Y., who traced the underlying motives in the development of hospitals past and present, pointing out that the fundamental quality of human sympathy is paramount in the establishment and maintenance of hospitals. Dr. Goldwater's paper appears in full on page 395 of this issue.

#### British Hospitals Association Represented

The first foreign guest introduced was Mr. J. Courtenay Buchanan, honorary secretary, British Hospitals Association, London, England, who represented that association at the Buffalo conference. In his remarks of appreciation of the invitation that the American Hospital Association had extended to the British Hospitals Association, he said that he had been sent to establish social relationship between the two associations and to carry home the lessons he could glean from American hospitals. American hospitals, he said, were generally superior to those of Great Britain in point of architecture, administrators and management but the hospitals of England were superior in respect to legislative provision.

Representing New Zealand hospitals were Drs. James S. Elliott, honorary surgeon, Wellington Hospital, Wellington, New Zealand, and Alec R. Falconer, medical superintendent, Dunedin Hospital, Dunedin, New Zealand. Dr. Elliott said that he had spent three weeks crossing the waters of the Pacific and the American continent in order to promote the union of English speaking peoples and to bring them into closer cooperation in the fields of medicine and hospitals. He described the organization of hospitals in New Zealand and told of the work which is being accomplished by the individual hospitals of New Zealand. Dr. Falconer conveyed the good wishes of the twenty-four hour old New Zealand Hospital Boards Association which was formed October 6, 1924. The other Australian guests introduced were Dr. Ralph Worrall, senior gynecologist, Sydney Hospital, Sydney, and Dr. H. B. DeVine, honorary senior surgeon, in-patient department, St. Vincent's Hospital, Melbourne, Australia.

#### Delegate from China Speaks

The Far East was represented by Dr. Percy Watson, Foo Chow Hospital, Foochow, China, who described the development of medicine and hospitals in China and the difficulties attendant upon the progress of medicine because of the prevalence of superstition and ignorance of disease. He said that the educational value of the pneumonic plague which had a 100 per cent mortality rate in some sections of China, could not be overestimated, for it awakened many of the natives to a realization of the necessity of scientific prevention and treatment. He said that the mission hospital had been able to win its way to

the heart of the Chinese people because of their great respect for anything in the name of religion, and that the future development of hospitals in China would depend upon their carrying out the religious message of the hospital.

#### Miss Eldredge Represents A. N. A.

A message of greeting to the association from the American Nurses' Association was conveyed by Miss Adda Eldredge, president of that association and director of nursing education for the state of Wisconsin. In her remarks, Miss Eldredge brought out that the American Nurses' Association is in cooperation with the American Hospital Association and is at present engaged in a three-fold undertaking, that of bringing together more closely the nurses of the country, that of raising the ethical standards of nursing, and that of making good citizens out of the members of the American Nurses' Association.

In the absence of Miss Jean E. Browne, president, Canadian Nurses' Association, Miss Jean I. Gunn, superintendent, Toronto General Hospital, Toronto, Ont., represented the new Canadian Nurses' Association and conveyed the greetings of that association to the members of the American Hospital Association.

The council on medical education and hospitals of the American Medical Association was represented by Dr. N. P. Colwell, Chicago, Ill., who briefly outlined the work which that body has done in the past few years, and said that the aim of the council was to encourage the establishment of fewer but better medical schools and that hospitals have a share in the responsibility of medical education, especially in respect to the problem of internships.

Mr. W. T. Buckley, representing the Buffalo Chamber of Commerce, welcomed the association for the twenty-sixth and future conferences, and expressed regret at the absence of Dr. A. R. Warner, executive secretary, Chicago, Ill., who had paved the way for good will toward the association in his preliminary arrangements for the Buffalo conference. The Hospital Exhibitors' Association was represented by Mr. B. A. Watson, president, who spoke on behalf of that body.

#### The Hospital's Role in Public Health

Wednesday morning's session, which proved to be one of the most interesting sessions of the conference, was devoted mainly to a round-table discussion which engendered unusual enthusiasm among the participants who thronged the ballroom of the armory. The session was opened by Mr. Henry A. Rowland, secretary, Department of Health, Toronto, Ont., who read a paper on the subject of "The Hospital in Relation to the Health Department." Mr. Rowland pointed out the close relationship of the hospital to public health work through its mission of teaching and its role in the care and treatment of communicable diseases. He described the Toronto system of coordination of public health with hospital care and social service work. Since 1910 the general mortality rate in Toronto, he said, has decreased from 15.1 per 1,000 population to 11.24 per cent—a decrease which has been brought about mainly through close cooperation of hospitals with public health work.

This close coordination has been encouraged by the provincial government which partly supports hospitals which employ a graduate nurse for follow-up work who is paid by the public health department. He also dwelt upon the striking work which Toronto is carrying on in

the care and prevention of venereal diseases. At present the city has six clinics which offer treatment at any hour of the day excluding Saturday and Sunday. Mr. Rowland believes that other cities will soon follow the path of Toronto in combining closely the services of hospitals and public health work and that the future will see the hospital assume its proper place as the cooperating agent of public health departments.

#### Per Capita Cost Figures and Efficiency

The round-table conference conducted by Dr. Joseph C. Doane, superintendent, Philadelphia General Hospital, Philadelphia, Pa., was opened by Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati, Ohio, who discussed the relative value of per capita cost figures as a measure of hospital efficiency. Dr. Bachmeyer brought out that gross comparisons are not justified since per capita costs depend upon the average occupancy, the policy of the hospital concerning salaries and the ratio of personnel to patients. As a guiding method of comparison he said to include all items of operating expense as opposed to capital expense and depreciation on buildings and equipment. The operating expense should be divided by the total number of days' treatment, adding to the total the number of patients admitted and discharged on the same day.

On the subject of the means of judging whether the hospital is performing its full duty to the community, Dr. Joseph B. Howland, superintendent, Peter Bent Brigham Hospital, Boston, Mass., offered the following as criteria of the hospital's efficiency: the adequate training of nurses for community needs; the supplying of funds for equipping the hospital in all its branches; and the education of the public in preventive medicine. In order to fulfill its mission to the community, he believes that the hospital should take care of all classes of people and all types of disease.

#### Aspects of the Intern Problem

The subject of getting and holding good interns was discussed by Dr. Winford H. Smith, director, Johns Hopkins Hospital, Baltimore, Md., who deplores the growing tendency of many hospitals to offer pay to interns in order to attract them at all. "It must be remembered," said Dr. Smith, "that the return from interns is in direct proportion to what is offered by the hospital in the way of educational advantages. He brought out that the factors of staff organization, type of work offered, the treatment of interns, the quality of supervisory work were things not to be overlooked in a consideration of making the hospital attractive to interns. In the discussion which followed from the floor the subject of an



The Modern Hospital Publishing Company booth where were displayed copies of MY PLEDGE AND CREED, THE MODERN HOSPITAL, The Nation's Health, bulletins, and other literature representative of the various types of services rendered to the hospital field.



Two prominent Chicago hospital men. (Left) Mr. Asa S. Bacon, superintendent, Presbyterian Hospital, and Mr. Frank S. Shaw, president, board of trustees of same hospital.

intern's breaking a contract with a hospital which had engaged his service for the year was brought up by a representative from the Pacific coast who said that in California such cases were reported to the licensing board and such interns were refused licenses to practice in the state.

In order to alleviate some of the difficulties which many hospitals experience in trying to get good interns, Mr. Richard P. Borden, trustee, Union Hospital, Fall River, Mass., suggested that a system of registration be adopted by the association as a bureau of information for the application of

internships. Such a method would be beneficial to hospitals in securing interns and would protect them from the contract breaking evil.

The consensus of opinion of the participants in the discussion was that the first step in attracting interns should be that of getting the hospitals on the approved list of the council on medical education of the American Medical Association, and that the bi-weekly conference with the interns was a good method to help keep them.

#### Making Nurse Training More Attractive

Ways and means of making the nurse's three years of training more profitable to her and the hospitals were discussed by Miss Helen Wood, dean of nursing, University of Rochester, Rochester, N. Y., who offered these four suggestions: (1) Relieve the nurse of non-nursing work as much as possible; (2) correlate theory and practice to a better extent so that ward service is more than routine duty; (3) offer more public health work in connection with ward service; (4) develop the nurse's care of the sick more on the case side in contrast to the factory piece work methods of training the nurse. Miss Wood's discussion was supplemented by Miss Caroline McKee, chief examiner, state medical board, Columbus, Ohio, who drew attention to the need of providing special educational training for nurses who are to become nursing teachers. In the future, she believes, we shall have to have two separate groups of nurses in training, supervisors, and those who will take care of patients. She made a strong plea for a greater application of scientific knowledge to the art of nursing.

#### Fire Prevention Methods

Hospital fire hazards were discussed by Mr. W. Crane Lyon, superintendent, Mercer Hospital, Trenton, N. J., who urged hospitals to defend themselves against fire both by preventive measures and by preparation to reduce loss of life and damage to property by confining the fire to small areas. He enumerated the causes of institutional fires according to their rank of percentage as follows: (1) heating equipment; (2) defective electric wiring; (3) smoking, matches; (4) sparks from chimneys and smoke stacks.

He strongly advised all hospitals to take precaution against fires by the installation of adequate sprinkler systems and by instituting a well-organized fire drill.

#### Stresses Personal Equation in Service

At the close of the round table Dr. John A. Hornsby, superintendent, University of Virginia Hospital, Charlottesville, Va., summarized the general opinion which had been expressed as to hospital service. "The personal equation," said Dr. Hornsby, "is after all the criterion of the service the hospital is rendering, but I think we can come to closer comparison of per capita costs in administration." He brought out that although service to the patient is paramount in any consideration of operation of hospitals yet hospital administrators can improve their methods of caring for patients by striving for greater efficiency of management of the hospital in all its details."

#### Nominating Committee Reports

The report of the nominating committee was presented by Mr. C. J. Cummings, superintendent, Tacoma General Hospital, Tacoma, Wash., who submitted the names which the committee had chosen for the various offices of the association, as follows: for president, Dr. Walter H. Conley, general medical superintendent, Department of Public Welfare, New York, N. Y., and Dr. C. S. Woods, superintendent, St. Luke's Hospital, Cleveland, Ohio; for first vice-president, Mr. Robert Jolly, superintendent, Baptist Hospital, Houston, Texas, and Dr. George F. Stephens, superintendent, Winnipeg General Hospital, Winnipeg, Man.; for second vice-president, Miss Evelyn H. Hall, superintendent, Seattle General Hospital, Seattle, Wash., and Miss Ada H. Patterson, superintendent, St. Luke's Hospital, St. Paul, Minn.; for third vice-president, Dr. Nathaniel W. Faxon, director, Strong Memorial Hospital, Rochester, N. Y., and Mr. Paul H. Fesler, superintendent, State University Hospital, Oklahoma City, Okla. The committee recommended that Mr. Asa S. Bacon be considered for reelection to the office of treasurer. The trustees nominated were Mr. Richard P. Borden, senior trustee of the association, Dr. Joseph B. Howland, superintendent, Massachusetts General Hospital, Boston, Mass., Dr. M. T. MacEachern, out-going president, and Mr. Daniel D. Test, superintendent, Pennsylvania Hospital, Philadelphia, Pa.

Through a series of motions from the floor it was decided to accept the committee's report but that the list of names be subject to additions nominated from the floor and that the list be kept open until the general election. Accordingly, the following names were added to the list of nominees by motions from the floor: For president, Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati, Ohio; for vice-president, Mr. Frank E. Chapman, director, Mt. Sinai Hospital, Cleveland, Ohio, and as an additional trustee, the Rev. H. L. Fritschel, superintendent, Milwaukee Hospital, Milwaukee, Wis.

#### Cleaning and Scientific Equipment Reports

Dr. Ralph B. Seem, director, Albert Merritt Billings Hospital, Chicago, Ill., presided over the meeting of the administration section on Wednesday afternoon, at which were discussed the report of the committee on cleaning, under the chairmanship of Dr. C. W. Munger, director, Grasslands Hospital, Valhalla, N. Y., and the report of the committee on clinical and scientific equipment and work, under the chairmanship of Dr. K. H. Van Norman,

superintendent, Charles T. Miller Hospital, St. Paul, Minn. These two reports were distributed in printed form and were not read at the meeting.

Dr. Munger stated that the report of his committee was now being presented for the third time and suggested that the report be published as a separate pamphlet so that it might be distributed to the various hospitals and used as a textbook on cleaning. He thought that some of the specifications given in the report would prove of interest and value. An abstract of this report appears on page 420 of this issue.

Dr. D. L. Richardson, superintendent, City Hospital, Providence, R. I., who is responsible for that part of the report which deals with terminal disinfection (section 3), stated that it is not the practice at his institution to sterilize mattresses. The mattresses and pillows are aired out-of-doors for a minimum of six hours, except in emergency when the weather does not permit this. The only exception to this is that soiled mattresses are sterilized by steam. The method of disinfecting linen in that hospital is as follows: The linen is thrown into a chute and dropped into a canvas bag in the basement. It is then placed on wheelbarrows and wheeled to the laundry in front of the washers. The water used in the washers is nearly at the boiling temperature.

#### Suggests Periodical Inspection of Cleaning

Dr. James U. Norris, superintendent, Woman's Hospital in the State of New York, New York, N. Y., briefly discussed the report which, he stated, was constructive and most valuable if a little incomplete in some minor points. He suggested the periodical inspection of all dishwashing and floor cleaning machines and also the inclusion in the report of comparative figures on the cost of cleaning in different institutions.

Dr. W. L. Babcock, director, Grace Hospital, Detroit, Mich., also discussed the report. With regard to the sterilization of mattresses by steam, he stated that only a small proportion of hospitals have steam sterilizers, and that at his institution a light sponging with soap and water is the method adopted. He also suggested that hospitals having grease and fat waste should make their own soap, having their laboratory man make an estimation of the alkali contained in the soap so that the alkali content can be kept low in order not to destroy the surfaces upon which it is used.

#### Favors Dry Method of Sterilizing

Mr. Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, Ill., in speaking of the sterilization of instruments, rubber gloves, glassware, etc., by boiling, stated that this is not satisfactory because of the condensation on the walls, and advocated the dry method by high pressure sterilizers. This method is in successful operation at his institution. Before the articles are put in the sterilizer, he stated, they should be wet with hot or cold water; otherwise they will have a white coating and will rust. Thirty-five pounds of high pressure steam are required at the apparatus, Mr. Bacon stated, and the instruments should be sterilized for fifteen minutes. A motion was carried that this report be accepted.

Dr. K. H. Van Norman, in presenting the report of the committee on clinical and scientific equipment and work, an abstract of which appears on page 419, stated that the work accomplished fell under three headings: diabetes—its treatment by insulin; physiotherapy in hospitals, and laboratories in hospitals. These subjects were taken

up separately by the following three members of the committee: Dr. F. R. Nuzum, director, Santa Barbara Cottage Hospital, Santa Barbara, Cal.; Dr. Charles E. Stewart, associate medical director, Battle Creek Sanitarium, Battle Creek, Mich.; and Mr. S. G. Davidson, superintendent, Butterworth Hospital, Grand Rapids, Mich., who presented to the meeting resumés of their respective sections of the report. Among those contributing to the brief discussion which followed the presentation of these reports was Dr. Walter E. List, superintendent, Minneapolis General Hospital, Minneapolis, Minn., who brought out that we have too many inadequately trained laboratory technicians and suggested the setting up of standards for the training of technicians through the establishment by hospitals of schools for this purpose. These schools, he said, should be regularly inspected by an officer of a state board or other agency and proper recognition given in the form of a certificate showing the subjects studied and the time spent in each.

Dr. W. L. Babcock, director, Grace Hospital, Detroit, Mich., moved that the report be accepted and the motion was seconded and carried.

#### Trustee Problems Discussed

One of Wednesday afternoon's sessions was devoted to a discussion of problems especially interesting to trustees. This meeting was presided over by Mr. Henry J. Fisher, president, Manhattan Eye, Ear and Throat Hospital, New York, N. Y., who opened the meeting by submitting the report of the committee of the trustee section.

This report comprised a resumé of replies received from letters addressed to one hundred prominent hospital trustees. The report touched upon the composition of boards of trustees, the relation of boards of trustees to the physicians of the hospital, the appointment of special committees of the board, the duties of the executive officers of the association in relation to the board of trustees and the medical staff, the relation of the hospital's medi-



The triumvirate from Mount Sinai Hospital, New York, N. Y. Left to right: Miss Bertha M. Wood, supervising dietitian; Dr. S. S. Goldwater, director, and Miss Elizabeth A. Greener, director, school of nursing.



Exhibit of the booth of the National Hospital Day committee showing the suggestions in the nature of various forms of publicity for that day.

cal practice to medical practice in the community at large and the relation of the nursing organization of the hospital to the hospital superintendent.

The report indicated that the majority of the trustees who responded to the questionnaire were in favor (1) of restricting membership on boards of trustees to laymen and physicians not practicing in the hospital; (2) the selection and appointment of physicians by the board of trustees; (3) some form of contact between the board of trustees and the medical staff other than through the superintendent; (4) a single board of trustees in full control of the hospital; (5) the unification of administrative authority in the hospital superintendent.

Following the report of the committee of the trustee section, Dr. E. M. Stanton, Ellis Hospital, Schenectady, N. Y., read a paper on "Hospital Organization from the Point of View of the Medical Staff." Dr. Stanton argued against appointing physicians on boards of trustees and held that the necessary contact between the board of trustees and the medical staff could be made by means of a medical advisory committee without vote. He held that a good superintendent, no matter how high his or her salary may be, is the best investment a hospital can make. He spoke in favor of the open staff hospital, contending that an open staff need not necessarily be an unorganized one. He held that active competition and the law of the survival of the fittest would eliminate poor physicians and surgeons from open hospitals. He favored the distribution of staff favors on the basis of accurate statistical records.

#### Stresses Educational Function of Hospitals

Miss Annie W. Goodrich, director, Yale School of Nursing, New Haven, Conn., spoke on "Hospital Organization from the Point of View of Community Relations." In Miss Goodrich's opinion the outstanding contribution which modern civilization has made to life is our educational system. Consequently she held that the relation of the hospital to education was an outstanding question. She pointed out that the educational function of the hospital has developed with the growth of science. In her opinion the hospital is to be credited with the present program of public health education. She held, moreover, that medical and nursing education is having a very definite effect in the home and in industry. She urged that the hospital continue its educational work by example within its own walls and encourage the inauguration

of periodical medical examination of its employees. In her opinion, hospitals have the desire and will to cooperate but lack the method; consequently she urged that the hospital personnel be educated in the method of cooperation in hospital work.

The theatre of the armory was crowded Wednesday evening at the meeting of the nursing section presided over by Miss Jean I. Gunn, R.N., superintendent of nurses, Toronto General Hospital, Toronto, Ont.

Dr. George D. O'Hanlon, medical superintendent, Bellevue and Allied Hospitals, New York, N. Y., first pre-

sented the report of the committee on training school budgets, of which committee he is the chairman. He stated that this report was compiled for the League of Nursing Education by Miss Elizabeth A. Greener, director, school of nursing, Mount Sinai Hospital, New York, N. Y., and her committee, and that he made a study of this report for the American Hospital Association, urging the acceptance of the recommendations contained therein. A motion was made and carried that the report which was published in the August 1924 issue of *THE MODERN HOSPITAL*, page 123, be referred to the board of trustees for their action.

The presentation of this report was followed by a paper entitled "To What Extent Should a Hospital Depend on the Students of the School of Nursing for the Nursing Service of the Hospital," by Miss Helen Wood, director, school of nursing, Strong Memorial Hospital, Rochester, N. Y.

#### Deplures Non-Nursing Routine Work

Miss Wood considered the problem suggested by the title of the paper from two viewpoints, that of the best care for the patient and that of the best education for the nurse. She pointed out that the nurse, graduate or under-graduate, is too valuable to be used for such routine work of the wards as is not nursing, and said that the employment of a certain number of ward maids, orderlies and clerks is desirable so that the student nurse may not be kept from the actual care of the patient which gives the experience necessary for her development as a nurse.

Referring to the employment of graduate nurses, Miss Wood gave three reasons for the addition of these graduates to the staff: (1) There are not enough students to care adequately for the patients; (2) a particular service may be so heavy that to staff it sufficiently with students would take these young women from other services where they are also needed or from their class room work; (3) graduate nurses should be employed because with an all-student staff it is frequently found necessary to move the student along so rapidly that the service is hampered by its constantly changing personnel; also a graduate on floor duty who remains at the same post for months can generally be used to substitute for a head nurse much more efficiently than can the average student.

With regard to the proportion in which other workers shall share with the student nurse the nursing service of

the hospital, Miss Wood feels that the responsibility of deciding this question should rest with the staff of the school of nursing, which should have sufficient funds available to employ graduates, orderlies, porters, ward maids or nurse helpers to supplement the work of the student nurses and thus maintain the efficient education of the nurse as well as the adequate care of the patient. The number of such people to be employed, she believes, should depend upon the type of hospital and the size of the school.

In concluding, Miss Wood said that if by "nursing service" we mean not the all inclusive matter of the care of the patient but actual nursing in its narrower meaning, then, she believes, all the nursing service of the hospital can be carried by the student body under the following four conditions: (1) A large enough school; (2) adequate housing and teaching facilities; (3) enough trained supervisors who can be in touch with students; (4) available funds to provide other workers for less technical duties or graduate nurses, when necessary, in places of extreme responsibility.

Discussion of this paper was opened by Miss Evelyn Wood, executive secretary, Central Council for Nursing Education, Chicago, Ill., who expressed agreement with the contentions of the paper and stated that the Rockefeller report on nursing education laid emphasis on the elimination of non-educational routine from the training of the nurse.

That education rather than wages must largely be the remuneration of the nurse was brought out by Mrs. Carl H. Davis, chairman, training school committee, Columbia Hospital, Milwaukee, Wis., in her paper on "The Relationship of the Superintendent of Nurses to the Board of Trustees." When the hospital enters into this relationship with the nurse, Mrs. Davis feels, the nursing service becomes not only a labor but an educational problem as well.

In this paper it was shown that the nurses' training school is but one of the many problems that confront the hospital board of trustees and the solution of its problems, like that of any other interest, such as purchasing or equipment, must be left to a special committee of study. To the training school committee is delegated the duty of learning the needs and safeguarding the interests of the school.

As Mrs. Davis sees it, the training school committee has three primary functions: (1) It should represent the interests of the school on the board, safeguarding the policy of the school during changes of administration and keeping informed of progress in nursing edu-

cation, so that it may know that the standards of the school are being maintained; (2) it should act in an advisory capacity to the principal on curriculum, faculty and student life; (3) it should consider the hospital from the patient's point of view so that nursing routine may be arranged with a view to his comfort as well as to the efficiency of the institution, and so that he may experience that courtesy in the nursing service which endear the hospital to the community.

Mrs. Davis' paper was discussed by Miss Ruth Hart Eddy, chairman, training school committee, Good Samaritan Hospital, Troy, N. Y., who took up in detail the points brought up in this paper, referring especially to the question of who should be included in the training school committee and expressing the opinion that it may be unwise to increase the committee from outside the board of trustees as this is apt to cause resentment on the part of some board member. Miss Eddy is in favor of keeping the committee rather small, possibly ten or twelve members, as too large a committee loses its influence with the board.

Dr. MacEachern, who was present during part of this meeting, spoke briefly on the question of the personnel of the training school committee, saying that it is not customary to select all this committee from the board of trustees as the board does not always contain persons qualified for such a committee. It is sometimes well, he said, to invite some of the educationists in the community to act on the committee.

"Is the preparation of the student nurse for special branches of nursing the responsibility of the school of nursing?" was the question discussed in a paper presented by Miss Elizabeth A. Greener as the closing topic of the nursing section.

Miss Greener is of the opinion that under present conditions it is impossible to do more in a two and one-half year nursing course than give the students a well balanced general training. In practically all hospitals today, large or small, good or bad, it is necessary that the nurse give satisfactory care to the patients, in addition to receiving practical and theoretical instruction. This leaves little time for electives and specialization.

She sees little virtue in a proposed system of affilia-



American College of Surgeons' booth where hospital standardization data were on exhibition.

tion between large and small hospitals, through which the small hospitals automatically become supply agencies for the larger and special hospitals. The home school, Miss Greener points out, has all the trouble, responsibility and expense of educating and training a student for her first year but is never able to profit by her experience.

"Unfortunately, it must be admitted," Miss Greener stated in her paper, "that except in a few isolated instances, such as are represented by Yale and Western Reserve universities, the probability of any radical change in the method of educating student nurses is remote."

### Long Training of Executives Impractical

Wednesday evening's administration section was devoted to the discussion of five committee reports referred to that section. Dr. C. G. Parnall, medical director, Rochester General Hospital, Rochester, N. Y., discussed the report of the committee on the training of hospital executives in the absence of Dr. F. A. Washburn, chairman of the committee. Dr. Parnall called attention particularly to the committee's recommendation that an effort be made to establish several fellowships in hospital administration under the National Research Council or other auspices, to finance qualified individuals in training for hospital administration. He said that the committee believed that at the present time it was not practical to promote long training periods for hospital executives, as the demand is not sufficient to justify such procedure.

Dr. A. C. Bachmeyer commented on the report, suggesting the desirability of establishing a short preliminary course of training for hospital executives without including public health training courses.

Major Edward A. Fitzpatrick, dean of the graduate school, Marquette University, Milwaukee, Wis., outlined the steps which that university has taken in the direction of training hospital executives. He said that the courses which have just been instituted at Marquette University this year were designed primarily for the benefit of the sisterhoods of the Catholic Hospital Association engaged in hospital work, but are open to anyone from the hospital field. The preliminary courses offered this year include a ten weeks' course in training for technicians, a similar course for radiologists and dietitians as well as practical field work in the various problems of hospital management.

### Definite Standards for Bed Sizes

A summary of the work done by the committee on general furnishings and supplies was given by Miss Margaret Rogers, superintendent, Lafayette Home Hospital, Lafayette, Ind. Miss Rogers outlined what the committee had accomplished in the way of selecting definite standards for bed sizes, and what had been done in cooperation with the department of commerce in the way of simplification of bed blanket sizes. Mr. R. M. Hudson, chief, division of simplified practice, U. S. Department of Commerce, Washington, D. C., showed slides illustrating what the department of commerce has accomplished in simplification of commodities in the various fields of industry.

On behalf of the legislation committee, Dr. E. T. Olsen, superintendent, Englewood Hospital, Chicago, Ill., chairman of the committee, called attention to the two recommendations of the committee, namely, that the association should establish a legislative service bureau, and that pending this establishment, the membership of the committee be increased by one member from each state and territory who would scrutinize all proposed legislation in

their respective states and report all proposed legislation affecting hospitals.

The conclusions of the committee on the relation of governmental bureaus and departments to hospitals were read by Chairman, Clarence E. Ford, superintendent, division of medical charities, New York State Board of Charities, Albany, N. Y. These included the recommendations of the committee that in each state there should be an appropriate state department or bureau having supervision over all the hospitals both public and private, and that in those states not having such a department initiative should be taken by the hospitals themselves in securing necessary legislation and adequate appropriations to carry on this work.

### Members Differ on Governmental Relations

Dr. A. L. Babcock, director, Grace Hospital, Detroit, Mich., commented on the report, saying that he had notified the committee that he desired his name withdrawn, as he was absent when the committee had composed the report and was not in agreement with its recommendations. He quoted sentences from the report and objected to the statement of the committee in regard to governmental supervision, particularly that part of the report which reads, "It seems, therefore, that the state through an appropriate department of its government, is the proper agency to supervise hospitals and to promote their interests from the governmental standpoint." Dr. Babcock said that he does not believe that the governmental standpoint is the right approach to the problem of raising standards of hospitals and of promoting their welfare, for the government, where it has had opportunity, in the case of state hospitals and other institutions, has not shown that it is the guiding agent of efficiency in its management of these institutions.

He contrasted the relative efficiency of government and municipal hospitals with that of private, endowed hospitals, showing that the latter have maintained higher standards of service and have taken the initiative in promoting the welfare of hospital administration. He said that he would have no objection to government inspection, if such meant merely the correlation of statistics which would be of benefit to the hospital field, but that was not what the committee had stated. In reply to Dr. Babcock's comment on the committee's report, Mr. Ford said that the committee was cognizant of the efficiency of the few large endowed hospitals, but that these represented but a part of the hospitals of the country and that in order to raise the standards of the other hospitals which form a large percentage of the total, the committee felt that government intervention was needed to insure the welfare and protection of these hospitals.

The reports of the committees were all accepted by the assembly with the exception of that of the committee on the relation of governmental bureaus and departments to hospitals which was referred to the committee for reconsideration and was, for the present, laid on the table.

### Teaching Function of a Hospital

There was a crowded attendance at Thursday morning's general session which was given over to the presentation of four papers of outstanding interest on the general subject of the teaching function of a hospital. President MacEachern was in the chair and the first paper was that of Dr. John A. Hornsby, superintendent, University of Virginia Hospital, Charlottesville, Va., the subject being "Some Special Problems of Teaching Hospitals."

"The factors that go to make up a teaching hospital,"

said Dr. Hornsby, "are interesting and highly specialized, for the teaching hospital is the highest type of institution for the care of the sick." He pointed out that it is the most expensive hospital to run for several reasons, (1) because it must be equipped with the finest and most

Miss Adda Eldredge, president, American Nurses' Association and director of nursing education for the state of Wisconsin, Madison, Wis., in her paper on "The Hospital as a Teaching Center for Nursing," took up not so much the subject of the theory and practice contained in

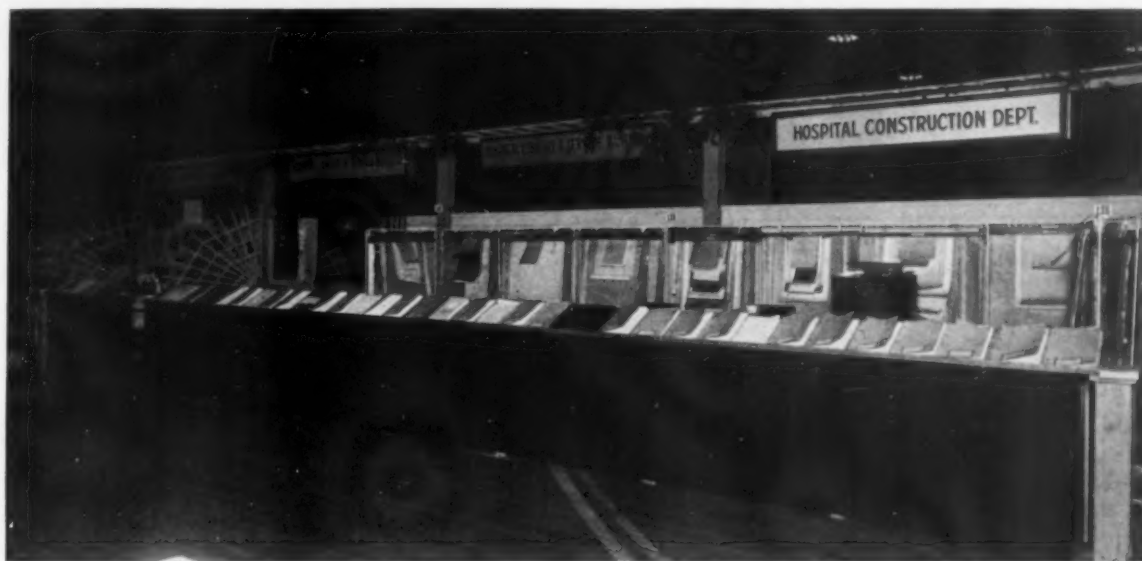


Exhibit of the Hospital Library and Service Bureau showing the hospital construction department where voluminous architectural and construction plans were displayed.

up-to-date apparatus, for which the initial outlay is high and the upkeep and replacement enormous; (2) it takes more interns because of the large number who must be on the wards and in the examining rooms; (3) it needs more nurses for a nurse must accompany each group on the wards and in the clinics. The personnel in a teaching hospital is thus considerably increased over that found necessary in other institutions, thereby greatly increasing the expenses of the hospital.

#### Disadvantages of Teaching Hospitals

Dr. Hornsby next pointed out some of the disadvantages of a teaching hospital, such as the fact that it cannot be so orderly, quiet and comfortable for the patient because of the almost constant presence of teachers and students. This, he feels, is more than compensated for by the better service that the sick receive in a teaching hospital, for there will be found the best and most capable medical men, selected not by the patient whose knowledge of medical skill is sometimes inadequate, but by trained educators, such as the president or the dean of the school. Upon the strength or weakness of the medical faculty, said Dr. Hornsby, will depend the success or failure of the teaching hospital, and authorities must choose well their faculty or the students will go elsewhere.

In his paper on "Possibilities of Post-Graduate Instruction by Non-Teaching Hospitals," Dr. W. P. Morrill, superintendent, Shreveport Charity Hospital, Shreveport, La., dwelt on the value of the advances that have been made during the last twenty years in the sciences of medicine and sanitation and the contribution to the welfare of future generations which is represented by the activities of the Council on Medical Education of the American Medical Association, the standardization program of the American College of Surgeons and the programs of research financed by private foundations. He pointed out, however, that the progress has not been symmetrical and in planning for the future, has overlooked present needs.

nursing education as commonly understood, but rather the things which she feels should be included in the unwritten curriculum of every school of nursing, for, as she sees it, they mean everything to the nurse, the public and the hospital.

Among other things, Miss Eldredge included the following: (1) humanity; (2) technique; (3) theory and practice; (4) cooperation; (5) social service; and (6) disease prevention.

Finally Miss Eldredge made a plea for more conferences between the nursing, the administrative and medical staffs which, she feels, would make for better cooperation and better team work and would keep women of good caliber in the hospitals.

#### Exchange Visits for Hospital Executives

Mr. John M. Smith, superintendent, Hahnemann Hospital, Philadelphia, Pa., put forward some practical and convincing suggestions in his paper on "Observation Courses for Hospital Executives." He advocated exchange visits by hospital executives to be made for the purpose of observing and studying methods in different institutions. One way in which these may be carried out, he said, is by means of a visit of several weeks which will give opportunity for gathering data on methods, equipment, personnel, and supplies.

"Time and money spent in this way," Mr. Smith said, "will pay big dividends to a hospital and the practice, if widely adopted, should result in a progressive improvement in the general hospital service, rendered at costs that are justified."

Mr. Smith's second plan is for a brief tour of inspection by a superintendent or department head to a selected list of hospitals. A few hours or even a day or two may be spent in each, and if the visitor has decided upon the particular type of information he wants, and possibly has compiled a brief set of questions covering points of special interest, he will find his tour of infinitely more value. Mr. Smith told of an admirable plan which has been

adopted in Philadelphia where a committee has been formed to collect information regarding the hospitals of the city. The facts so gathered will be afterwards carefully arranged and printed in leaflet form and will be available for visitors who will thus be in a position to know what to see and where to see it as far as the hospital world of Philadelphia is concerned.

The construction section held a meeting Thursday afternoon under the chairmanship of Mr. E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago, Ill. The report of the committee on buildings was read by Dr. S. S. Goldwater, chairman (for abstract see page 417). The report was discussed by Mr. Oliver H. Bartine, superintendent, Hospital for Joint Diseases, New York, N. Y.

### Laboratory Planning Discussed

Mr. C. J. Cummings, superintendent, Tacoma General Hospital, Tacoma, Wash., then read a brief paper on "Planning and Construction of Laboratories" in which he emphasized the need of planning with a view to accuracy, dependability and speed. While recognizing the value of well-planned laboratories he contended that the correct interpretation of laboratory findings and x-ray films was still more important. In the planning of the x-ray therapy room he urged that they be made large enough as they require adequate space for machinery of high voltage.

In a brief resumé of his report on "Adaptability of Tile to Hospital Requirements" Mr. Carl H. Geister, industrial fellow, Mellon Institute of Industrial Research, University of Pittsburgh, Pittsburgh, Pa., discussed the requirements essential in an ideal floor material and arrived at the following conclusions, which are the result of an investigation on tile being carried on at the Mellon Institute. The report will be published in our December issue.

### Social Service in the Small Hospital

What can be done in the way of developing hospital social service in the small hospital was the keynote of the papers and discussions of the social service section held Thursday afternoon, October 9, under the chairmanship of Miss Ida M. Cannon, director, social service department, Massachusetts General Hospital, Boston, Mass.

The first paper of the session, "Application of Social Service to the Problem of the Small Hospital," was presented by Mrs. Martha J. Megee, social service consultant, department of public welfare, Harrisburg, Pa., who recounted several examples of patients who had left the small hospital and were in need of social service follow-up work. She showed the definite need for the development of social service work in the small hospital and offered suggestions on how such service may be furnished without becoming a serious burden to the hospital financially.

She pointed out that the small hospital needed social service work to make its contact with patients more humane and to facilitate its credit work with patients. "Credit work," Mrs. Megee said, "can and does deter many people from applying for medical aid. The only way that this difficulty can be overcome is by having credit work socially administered by a competent social service worker."

### Methods of Handling Social Service Work

Mrs. Megee gave three methods by which small hospitals which feel that they cannot employ a full-time social service worker may avail themselves of the part-

time services of a trained worker. The first method was that of having the small hospital cooperate with the local social agencies, such as the Red Cross, associated charities, etc., in securing their aid as an approach to charitable cases. The second method was that of securing the services of a trained worker through the cooperation of social agencies of the community which would help defray the expense of such service. The third method was that of several small hospitals in adjacent communities employing a social service worker to divide her time among them or to supervise credit workers who would serve the hospital under her direction. She advocated strongly the appointment of a socially minded credit worker either from the American Association of Hospital Social Workers or from the state departments of welfare, to help small hospitals in their pioneer stages of social service work.

Mrs. Megee's paper was discussed by Miss Ethel H. Bates, superintendent, Olean General Hospital, Olean, N. Y., who said that hospital people are beginning to realize that the patients of the small hospital need social service as much as those of larger hospitals, but that before this service can be developed there is need for a campaign of educational enlightenment to show the community and boards of trustees that this service is really needed.

### Therapeutic Value of Good Books

"Mutual Interests of Hospital Social Service and the Patients' Library" was the subject of the paper presented by Miss Perrie Jones, St. Paul Public Library, St. Paul, Minn., who left the impression with her audience that the therapeutic value of good books should be recognized in the hospital just as much as that of occupational therapy. She believes that where it is possible the hospital should employ a full-time librarian to make an intelligent selection of books for the various patients, with whose mental condition she should acquaint herself, and that all hospitals large and small should have a part-time librarian so that the distribution of books among patients should not be turned over to assistants who are not qualified to make an intelligent selection.

### Handling Infectious Diseases

Thursday evening's general session centered largely around hospital operation. The first paper presented, by Dr. D. L. Richardson, superintendent, City Hospital, Providence, R. I., was on the subject of "Hospitalization of Infectious Diseases."

Dr. Richardson traced the method of handling infectious diseases from the earliest times, bringing out the fact that exact knowledge concerning them has been crystallized during the last forty years. Now that the airborne theory of infection has been abandoned for the contact theory, he brought out, it is possible through the employment of medical asepsis to have contagious wards in general hospitals. This means, of course, that doctors and nurses must be carefully trained in technique.

Dr. Richardson believes that such diseases as typhoid fever, epidemic meningitis, acute poliomyelitis, pneumonia, tonsillitis and other acute throat conditions should be cared for in an infectious disease hospital or ward. If this is done, he says, there will be less danger of cross infection, less danger to nurses and doctors, and better care and treatment for the patients when segregated in a ward by themselves.

"To render wide service at a reasonable cost and with complete safety," Dr. Richardson said in conclusion, "all

acute infectious diseases should be cared for in isolation hospitals or in wards set apart for their treatment, in which medical asepsis is rigidly enforced. Isolation hospitals of less than fifty beds, however, are not economical to administer and these should be attached to general hospitals, where expense will be less, service better, and, if they are properly managed, safety assured."

Following a brief discussion of Dr. Richardson's paper by Dr. Norman C. Bender, director, acute communicable disease service, Buffalo City Hospital, Buffalo, N. Y., Mr. Frank E. Chapman, director, Mount Sinai Hospital, Cleveland, Ohio talked on the practical subject of "The Status of the Budget in the Operation of a Hospital."

#### Defines Budget System

This address gained much in emphasis from Mr. Chapman's clear and forceful manner of presenting his subject. He defined a budget system as nothing more nor less than an orderly procedure which requires a constant application of the best known principles of business conduct in financial affairs of an activity, with the accompanying requisite of a continuous endeavor to keep these activities alive in the acts of the individuals charged with the operation of the system. There, he said, is the keynote of a properly functioning budget system in a hospital.

Mr. Chapman feels that service to the patient should be paramount, but should be guided by a definitely outlined method of procedure.

As a primary requisite to a budget system there must be records of performance, a definite system of proper accounting of financial performance as to income and expense and a proper recording of the vital facts of an institution.

Hospital accounting methods are too apt to be slipshod, in Mr. Chapman's opinion, and there is no uniformity in the method in which income and expense accounts are handled. The hospital must set up for itself some uniform procedure, and must live up to it.

Mr. Chapman has for fifteen years run his hospital on a budget system and for seven years has never been off more than three per cent in his estimate. He feels that the degree of service to patients is increased by the budget system.

Following are several "Don'ts" which the speaker suggested to his audience: Don't guess—make every figure the result of the closest calculation you can make. Don't try to work a budget alone—take your department heads into your confidence. Don't transfer from one account to another. Don't disregard your budget at the time of purchase. Don't change your mind in the middle of the year on a policy that entails expenditures except in emergency. Don't change the rate of compensation on your payroll budget—increase salaries coincident with the

budget period. Don't be disheartened.

Dr. Joseph R. Morrow, superintendent, Bergen County Hospital for Communicable Diseases, Ridgewood, N. J., in his paper on "The Relation of the State and County Hospital to the Prevention and Care of Disease," said:

"Public and private agencies for health education have succeeded in arousing the interest of intelligent people in health matters, and consequently the hospitals, which are funded by taxpayers, bear their scrutiny and receive either approval or disapproval."

#### Cooperation in Hospital and Community Work

A number of ways in which the community and the hospital can go hand in hand in disease prevention were outlined by Dr. Morrow. Through his own hospital, the Bergen County, an educational campaign on the Schick-test was carried out in cooperation with school boards and press, and the number of patients in the diphtheria wards of the hospital was cut in half.

The hospital's greatest opportunity in disease prevention, Dr. Morrow believes, consists in teaching the patients the rules of hygienic living and contact infection and in disproving the old theory of air-borne disease. Also through letters, posters, newspaper stories, lectures, contacts with clubs and fraternal organizations, cooperation with local and state boards of health, and cordial relationship with the doctors of the community, state and county hospitals can accomplish a great work in disease prevention.

Dr. E. M. Bluestone, assistant director, Mt. Sinai Hospital, New York, gave the concluding paper of the evening, a scholarly presentation of the subject, "Some Fundamental Problems in Hospital Administration." This will be published in our December issue.

#### Second Round-Table Session

The first and second round-tables of the conference proved so popular and successful in every way that it was decided to devote the entire session Friday morning to the third round-table conference, conducted by Mr. Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, Ill. That this third round-table was popular was evidenced by the fact that the ballroom of the armory was filled to capacity and the audience manifested an unusually enthusiastic interest throughout the entire session, which lasted an hour and a half longer than the time scheduled.

The first topic discussed was the question, "Which is better, dressing patients in wards or taking them to a central dressing room?" which was discussed by Miss Alice M. Gags, superintendent, J. N. Norton Memorial Infirmary, Louisville, Ky., who advocated the central dressing room as the more desirable method of dressing pa-



Three views of the model kitchen showing the correct equipment and arrangement for the kitchen of a seventy-five-bed hospital.

tients, as such an arrangement is more satisfactory from the standpoint of keeping the ward in good condition. Her discussion was supplemented by that of Dr. Lewis A. Sexton, superintendent, Hartford Hospital, Hartford, Conn., read by Mr. Bacon, in the absence of Dr. Sexton. Dr. Sexton's survey of the subject showed that fifty-eight per cent of the hospitals replying to a questionnaire did all their dressing in the wards, while twenty-four per cent do their dressing in rooms off the wards. He summarized the advantages of the central dressing room as follows: (1) Better technique can be acquired; (2) disagreeable odors of medicines can be dispensed with; (3) undue noise can thus be checked; (4) the nurse is thereby given an opportunity of arranging the patient's bed in his or her absence; (5) it saves time, particularly in the case of ambulatory cases; (6) it saves sheets, floors, and furniture from being damaged.

The disadvantages of the central dressing room were enumerated as (1) the removal of patients often causes discomfort to them; (2) this method is often impracticable because of the lack of sufficient help; (3) too much time is consumed in removing patients; (4) convalescence is often retarded by too much handling; (5) there is danger of accidents in such an arrangement; (6) the method of providing screens around the bed while dressing patients has proved to be better.

The discussion on workmen's compensation and the hospital was opened by Mr. Richard P. Borden, trustee, Union Hospital, Fall River, Mass., who focused attention on the difficulties attendant upon the hospitals of the various states adjusting themselves to the laws of those states in regard to the care of the workmen. The crux of the situation, according to Mr. Borden, is that the insurance companies claim that they are unable to pay full charges for hospital care unless they raise the rate of insurance. The discussion brought out forcibly the fact that it is up to the hospitals of the country to get better laws of protection. Mr. Borden urged that the association should investigate the status of legislation in each state and then adopt what means seems best for handling such cases.

#### Fumigation Not Necessary

The question of fumigation after contagion was discussed by Mr. T. T. Murray, superintendent, City Hospital, Saskatoon, Sask., who expressed his belief that, except in rare cases, fumigation after contagion is unnecessary. His opinion was shared by many.

The question of nurses' taking oral orders from a physician was discussed by Mrs. Nan H. Ewing, principal, school of nursing, Ravenswood Hospital, Chicago, Ill., who read the replies to the questionnaire on this subject sent to a large number of physicians and hospital executives, who were almost unanimous in their decision that all orders should be written, for the protection of both physician and nurse.

The subject was also discussed by Miss Marietta Barnaby, superintendent, Henry Heywood Hospital, Gardner, Mass., who expressed the consensus of opinion that it is the best practice to have all orders written.

#### Hospitals Need to Help Empty Beds

The question of how hospital beds can be kept full, in view of the fact that the United States census shows that only fifty-two per cent of the total number of hospital beds of the country are filled during the entire year, was discussed by Mr. Paul H. Fesler, superintendent,

State University Hospital, Oklahoma City, Okla., who took the negative side of the question. He read the statistics which had been gathered from over one hundred and fifty hospitals in the country, showing that the average occupancy is 78.8 per cent. "What we really need," said Mr. Fesler, "is to put forth effort towards emptying rather than filling hospital beds, for in many communities the number of beds falls far short of the number required to serve adequately the needs of the community." He showed that the apparently large percentage of unused beds is accounted for by an unwarranted number of hospitals in communities where the hospital is filled to capacity in the winter and treats but four or five patients during the summer. He believes that the problem can be met only by a more intelligent distribution of hospitals according to the type of population; that is, more in industrial centers and fewer in purely residential communities. He believes that if filling hospital beds means opening the hospital doors to all practitioners, regardless of ethical standards, it is the duty of the association to see that hospital beds are not kept full.

"Can high standard nursing efficiency be maintained in a hospital giving a two years' course?" was a question which aroused a great deal of interesting comment. The discussion was opened by Miss Adah H. Patterson, superintendent, St. Luke's Hospital, St. Paul, Minn., who carefully weighed the subject both from the viewpoint of the nurse and of the hospital, and concluded that a third year is the most important year in the nurses' training and is needed to round out her course and should not in any sense be considered as non-essential to the proper training of the nurse.

In direct contrast to the viewpoint of Miss Patterson was that of Dr. E. T. Olsen, superintendent, Englewood Hospital, Chicago, Ill., at whose hospital the two-year course is in operation. Dr. Olsen argued that nurses can be just as thoroughly trained in the two-year as in the three-year course, that they pass the state board examinations just as well, that the physical strain is no greater, and that this arrangement is a great economic advantage both to the nurse and the hospital, as the public can be supplied with one-third more nurses every year. He said that the only valid objection to the two-year arrangement is that it increases the labor turnover and thereby increases the overhead expenses of the hospital. Dr. Olsen was firm in his conviction that the essentials of nursing can be obtained in two years and that special training should be a matter of a graduate course.

#### Two-Year Nursing Course Unsatisfactory

Dr. L. G. Reynolds, superintendent, Methodist Hospital of Southern California, Los Angeles, Cal., said that after giving the two-year course a fair trial in his hospital the conclusion had been reached that such an arrangement lowered the standard of the nursing school to that of a carpenter trade instead of placing it on a high educational plane such as it should have alongside the other professions. He said that the two-year course was unfair to nurses in that most graduates are three-year students and that the two-year students suffer in their competition with them.

Miss Adda Eldredge, president, American Nurses' Association, Milwaukee, Wis., commented upon the previous discussions and said that while at the present time there is wide divergence of opinion among nurses on this subject, the American Nurses' Association had not taken a stand in regard to the length of training, but that what

it wanted is adequate training, which means a well-organized school both as to theory and practice, whether it take two or three years to acquire that thorough training.

### Advantages of Psychiatric Department

Whether or not general hospitals should have a psychiatric department was discussed by Dr. M. F. Steele, superintendent, Hope Methodist Hospital, Fort Wayne, Ind., who said that the advantages of the psychiatric department are three-fold; namely, that it gives nurses the opportunity for that type of training, that advantages of such care enhance the service of the hospital, and that incipient mental cases are thus able to be watched more closely by the physician-in-charge. He enumerated six fundamentals in the maintenance of a successful psychiatric department, as follow: (1) Nurses in charge must have had special training in psychiatric hospitals; (2) enough nurses must be kept on duty to keep constant watch over patients; (3) absolute quiet must be maintained; (4) comfortable rooms and beds with appropriate interior decoration must be provided; (5) adequate hydrotherapeutic treatment must be provided; massage and other physio-therapeutic treatment is indispensable. Dr. Steele made it clear that incurable cases could not be handled and should not be admitted to the general hospital.

The question of keeping dietary records of the patient, the same to be made a part of the permanent records of the hospital, was discussed by Dr. B. C. Caldwell, superintendent, University Hospital, Iowa City, Iowa, who expressed the opinion that dietary records should be kept, but should not be added to the voluminous reports which make up the permanent records. He said that in special cases, which are relatively few, where dietary treatment is a significant part of the treatment it might be desirable to add such data to the permanent history of the patient.

### Economy Effected by Water Softener

The economy effected by the use of a water softener in the hospital was discussed by Dr. A. K. Haywood, superintendent, Montreal General Hospital, Montreal, Que., who declared himself an advocate of the use of a water softener from the experience of his own hospital. The use of a water softener has effected an enormous saving both in consumption of soap and soda, which has been cut in two, to say nothing of the economy in fuel. He estimated that in all the use of a water softener saves his hospital \$1,500 a year. He said that in purchasing boilers for this purpose it should not be overlooked that a large quantity of salt is required to flush out the apparatus.

In the case of his hospital it required 300 pounds of salt a week to flush out the apparatus. He also advised the purchase of a large boiler. The subject was also discussed by Dr. W. C. Lyon, superintendent, Mercer

Hospital, Trenton, N. J., who gave as a deciding factor in the purchase of a water softener the depth of scale on water in the boilers. He said that the hospital needs a water softener in proportion to the scale formation, and advocated the use of a water softener as an economy in the consumption of coal and in prolonging the life of linens used in the hospital.

### Should Not Be Financed by Staff Member

How to account for missing articles and valuables of the patient was discussed by Dr. John D. Spelman, superintendent, Touro Infirmary, New Orleans, La., who advocated that hospitals should hold themselves as not responsible either in private rooms or wards and suggested that hospitals have vaults for valuables, that such be

recorded and that the checking form, which should be bound with the recorder, be signed by the patient as a safeguard for the hospital. He said that in regard to the laundering of patients' personal effects, his hospital followed the method of sorting out such articles and placing them in lockers, and that patients' claims for valuables had thus been reduced to a minimum.

The attitude which a non-teaching hospital should take toward a staff member who asks for an intern to be assigned to him and is willing to finance the intern was discussed by Mr. Henry G. Yearick, superintendent, Homeopathic Hospital, Pittsburgh, Pa., who ex-

pressed himself as definitely opposed to such an arrangement because he did not feel that a hospital could conscientiously delegate an intern to a physician exclusively, without showing partiality and without division of authority which would cause trouble between the interns and the hospital.

What is understood by an endowed room was explained by Dr. L. G. Reynolds, superintendent, Methodist Hospital of Southern California, Los Angeles, Cal., who defined the two types of endowed rooms, as that which is donated by an organization which designated clearly who shall have the use of that room, and the room that is furnished as a memorial by a philanthropic individual to be used for the indigent sick. He advocated that in order to avoid the entangling alliances which sometimes arise when the benefactor attempts to dictate who shall be cared for in the room, hospitals see to it that the beneficiaries of such endowed rooms be carefully defined in the agreement between the hospital and the benefactor.

The discussion on whether or not the hospital should care for, free of charge, a patient who contracts a communicable disease through the mistaken diagnosis of another case, was led by Mr. Boris Fingerhood, superintendent, United Israel Zion Hospital, Brooklyn, N. Y., who brought out that the hospital is responsible for the physician and should thus take care of the patient free of charge, except in cases where, through the physician's neglect, there has been a careless examination upon which he has based diagnosis in which case the physician should



American Medical Association booth where were displayed posters and other literature illustrating the services of the association.

be responsible for the hospital charges. It was brought out in the discussion that contagious diseases are so difficult of diagnosis, and are often contracted without carelessness, that the hospitals should not bear the expense of a patient's care unless it can be proved that the disease was contracted through carelessness.

### University Training Course Not Practical

Whether or not a training school for hospital executives should be speeded up and whether or not it should be a university course was discussed by Mr. Louis C. Trimble, superintendent, Post-Graduate Medical School and Hospital, New York, N. Y., who believes that at present such a university course is not practical unless it can be combined with a sufficient amount of laboratory work, but that in the future such a course should be offered which would combine theoretical training with fifty per cent of the practical work to be done in big hospitals throughout the country.

### Superintendents Ex-officio Staff Members

The advisability of inviting superintendents to all staff meetings was taken up by Mrs. H. M. F. Bowman, superintendent, Women's College Hospital, Toronto, Ont., who believes that the superintendent should be an ex-officio member of all staff meetings and committees.

What temperature is the index between an infected and a non-infected obstetrical case was discussed by Mrs. V. R. Hoener, superintendent, Chicago Memorial Hospital, Chicago, Ill., who said that the question had two aspects, that of the medical and that of the hospital, respectively, and that the absence of high temperature did not always guarantee against infection. She said that in her hospital a temperature of 100 degrees Fahrenheit for twenty-four hours was considered as skeptical and treated as an infected case.

### English Delegate Adds to Discussion

At the close of the round-table conference the foreign guests were asked to contribute in rounding out a summary of the discussions. Mr. J. Courtenay Buchanan, representing the British Hospitals Association, drew attention to the second topic of discussion, that of workmen's compensation and the hospitals, and advocated that the American Hospital Association take up the question seriously in the light of what the British hospitals had done in this direction. In regard to the contraction of contagious diseases through a mistaken diagnosis, he said that in England negligence had to be proved before responsibility for such could be placed on the hospital or physician. He concluded by saying that the problems of the British and American hospitals were similar in many respects and that both systems needed cooperation plus service as their aim in promoting the welfare of patients.

### New Zealand Guest Expresses His Opinion

Dr. James S. Elliott, honorary surgeon, Wellington Hospital, Wellington, New Zealand, expressed surprise that American hospitals experienced so much difficulty in regard to workmen's compensation laws, and believes that the American Hospital Association should be able to get an advantageous policy from some large insurance house with branch offices throughout the country. He declared himself not in favor of psychiatric departments in general hospitals because, in his experience, they had not proved satisfactory. He believes that all psychiatric patients should be treated in psychopathic hospitals.

In expressing his ideas concerning the various ques-

tions discussed, Mr. James R. Mays, superintendent, Union Hospital, Fall River, Mass., also one of the summarizing judges, said that with regard to the question of workmen's compensation and the hospital he did not see that it was the place of the hospital to concern itself with lowering the insurance rate of workers. He expressed himself in favor of fumigation, and against verbal orders for nurses. He believes that publicity is the big factor to be considered in attempting to keep hospital beds filled, for, unless the people of the community place confidence in the hospital which calls for a knowledge of the type of work it is doing, people will not avail themselves of its services. He also feels that the dietary records should be kept as a permanent record in the hospital.

### Bachmeyer Chosen President-elect

The general session and business meeting Friday afternoon opened with an announcement of the following election results: President-elect, Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati, Ohio; first vice-president, Mr. Robert Jolly, superintendent, Baptist Hospital, Houston, Texas; second vice-president, Miss Evelyn H. Hall, superintendent, Seattle General Hospital, Seattle, Wash.; third vice-president, Dr. Nathaniel W. Faxon, director, Strong Memorial Hospital, Rochester, N. Y.; treasurer, Mr. Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, Ill.; trustees, Mr. Richard P. Borden, trustee, Union Hospital, Fall River, Mass., and Mr. Daniel D. Test, superintendent, Pennsylvania Hospital, Philadelphia, Pa.

### Minimum Standard for Dispensaries

The committee on resolutions recommended the following resolutions:

(1) "It is the sense of the section on dispensaries that the committee on out-patient work be instructed to submit to the trustees of the American Hospital Association within three months a comprehensive report, together with definite recommendations, on a minimum standard for dispensaries.

"These recommendations should embody details on the conduct and management of dispensaries, and especially on the following points: (a) adequate technical equipment; (b) responsibilities and duties of the senior medical staff of the hospital towards the medical work in the dispensary; (c) prerequisites to the appointment of members of the medical staff of the dispensary. (Submitted by Boris Fingerhood, secretary, section on out-patient work.)

(2) Submitted by the representatives of the state and provincial associations: "In order to encourage the formation of regional associations, and to bring them into closer contact with the American Hospital Association, the trustees of that association are hereby requested to formulate a plan under which such regional associations may be organized, to outline the scope of their activities, and to define their relationship to the American Hospital Association.

"The board of trustees is further requested to call to their assistance, in the drafting of this plan, such representatives of existing regional associations as they may deem advisable.

"The board of trustees is further requested to submit their plan to the regional associations, and to call a meeting of the representatives of the same to meet with the trustees at a proper time and place to discuss such criticisms and suggestions as may have been received, and who, in conjunction with the trustees, shall

have power to formulate and adopt an organization plan which will be final."

### Gratitude Expressed to Local Committee

(3) "The committee recommends that an expression of thanks from the American Hospital Association for helpful assistance and cooperation in making the twenty-sixth conference a great success be made to the following: Dr. W. S. Goodale, chairman, and members of the local executive committee; Dr. Renwick R. Ross, chairman, and members of the local general reception committee; Mr. Elmer C. Green, chairman, and other members of the hotel committee; Colonel William F. Schohl, commanding officer, and Captain Edward E. Holden, armourer, 106th Field Artillery; to the press; to the state nurses' association; to the Exhibitors' Association; to the Statler Hotel, where some of the meetings and the banquet were held; to the mayor and citizens of the city of Buffalo and to all others who participated in the program and contributed to the success of the conference.

With regard to House of Representatives bill No. 6645, which affects the use of denatured alcohol but which does not, in the estimation of the committee on resolutions, sufficiently provide for the needs of hospitals, the committee believed it more wise to refer this matter to the trustees for action rather than attempt to draft a resolution which might or might not cover the problem in all its aspects.

Following a few concluding remarks by Dr. MacEachern, Mr. E. S. Gilmore took the chair, and, bespeaking the cooperation of the entire membership of the association, pledged his best effort during the term as president. He then announced the following committee appointments:

### President Gilmore Announces Committees

Construction and Rules—chairman, Mr. Richard P. Borden, trustee, Union Hospital, Fall River, Mass.; Rev. H. L. Fritschel, superintendent, Milwaukee Hospital, Milwaukee, Wis.; Miss Blanche M. Fuller, superintendent, Nebraska Methodist Hospital, Omaha, Neb.

Resolutions—chairman, Dr. L. H. Burlingham, superintendent, Barnes Hospital, St. Louis, Mo.; Mr. G. D. Crain, Jr., editorial director, *Hospital Management*, Chicago, Ill.; Miss Adda Eldredge, R. N., president, American Nurses' Association, Madison, Wis.

Legislative—chairman, Dr. E. T. Olsen, superintendent, Englewood Hospital, Chicago, Ill.; Mr. B. B. Sandidge, superintendent, Emergency Hospital, Washington, D. C.; Dr. B. W. Caldwell, superintendent, University of Iowa Hospital, Iowa City, Iowa.

Nominating—chairman, Rev. L. G. Reynolds, superintendent, Methodist Hospital of Southern California, Los Angeles, Cal.; Mr. Robert Jolly, superintendent, Baptist Hospital, Houston, Texas; Mrs. Gertrude Fuller, superintendent, St. Luke's Hospital, Fargo, N. D.; Mr. Robert E. Neff, superintendent, Robert W. Long Hospital, Indian-

apolis, Ind.; Dr. Stewart Hamilton, superintendent, Harper Hospital, Detroit, Mich.

Membership—chairman, Dr. Lewis A. Sexton, superintendent, Hartford Hospital, Hartford, Conn.; Dr. C. G. Parnall, medical director, Rochester General Hospital, Rochester, N. Y.; Dr. O. F. Ball, president, Modern Hospital Publishing Co., Inc., Chicago, Ill.; Miss Geraldine Borland, superintendent, Hermann Hospital, Houston, Texas.

Out-Patient—chairman, Dr. Alec N. Thomson, medical secretary, Committee on Dispensary Development, New York, N. Y.; Dr. J. L. McElroy, superintendent, Ancker Memorial Hospital, St. Paul, Minn.; Dr. Donald Smelzer, Buffalo General Hospital, Buffalo, N. Y.

National Hospital Day—chairman, Mr. C. J. Cummings, superintendent, Tacoma General Hospital, Tacoma, Wash.; vice president, Dr. M. T. MacEachern, associate director, American College of Surgeons, Chicago, Ill.; Dr. George F. Stephens, superintendent, Winnipeg General Hospital, Winnipeg, Manitoba; Mr. W. W. Rawson, superintendent, Thomas D. Dee Memorial Hospital, Ogden, Utah; Dr. C. S. Woods, superintendent, St. Luke's Hospital, Cleveland, Ohio; Dr. Hugh S. Cumming, surgeon general, U. S. Public Health Service, Washington, D. C.; Mr. J. B. Franklin, superintendent, Baylor Hospital, Dallas, Texas; Mr. M. D. Foley, manager editor, *Hospital Management*, Chicago, Ill.; Mr. J. J. Weber, editor, *THE MODERN HOSPITAL*, Chicago, Ill.; Miss Mary M. Roberts, editor, *American Journal of Nursing*, New York, N. Y.; Rev. P. J. Mahan, acting vice-president, Catholic Hospital Association, Chicago, Ill.; Miss Meta Pennock, manager editor, *Trained Nurse and Hospital*

*Review*, New York, N. Y.; Miss Mary E. Henry, superintendent, Pottstown, Pa.



Booth of the National Child Welfare Association lined with posters educational value to the public.

### Resolution Concerning Foreign Guests

The following motion was then made by Mr. J. J. Weber, editor, *THE MODERN HOSPITAL*, Chicago, Ill.

*Be it resolved*, that the American Hospital Association express its deep appreciation at having been honored at its twenty-sixth annual conference held in Buffalo, October 6-10, 1924, by the presence of Mr. J. Courtenay Buchanan, C. B. E., honorary secretary, British Hospitals Association, London, England; Dr. James Sands Elliott, honorary surgeon, Wellington Hospital, Wellington, New Zealand; Dr. Alec R. Falconer, C. B. E., medical superintendent, Dunedin Hospital, and Mr. W. S. Downs, business manager, board of trustees, Olago Hospital, Dunedin, New Zealand; Dr. Percy Watson, Foo Chow Hospital, Foo Chow, China, and Dr. T. D. Sloan, Peking Union Medical School Hospital, Peking, China, and sincerely hopes their attendance will establish a precedent for future years.

*Be it further resolved*, that a copy of this resolution be transmitted to the aforementioned representatives and guests.

The conference concluded with informal remarks by Dr. A. C. Bachmeyer, the president-elect.

## "MY PLEDGE AND CREED" WINS UNIVERSAL APPROVAL AT BUFFALO CONFERENCE

THE spirit of service pervading the Buffalo conference found expression in MY PLEDGE AND CREED, which was welcomed by all present as a guiding influence toward the attainment of the ideals for which all hospital people should strive.

In his address at the opening general session of the conference, President MacEachern commended MY PLEDGE AND CREED, when he said, "This Pledge and Creed is the result of much thought—that is why it is so full of beautiful interpretation. I wish MY PLEDGE AND CREED could be adopted and put into universal effect throughout every hospital in America. What great change would come over many of our institutions! I would therefore recommend that the association take more interest in hospital ethics, establish a code of ethics and adopt for universal use MY PLEDGE AND CREED."

Dr. MacEachern also flashed a copy of MY PLEDGE AND CREED upon the screen, and at the end of the invocation the Rev. Cameron J. Davis, rector, Trinity Protestant Episcopal Church, Buffalo, read the words of the Pledge and Creed which were repeated by the entire assembly. That the Pledge and Creed met with hearty approval was evidenced by a motion which was made and carried that it be recommended for adoption by the association. A facsimile of MY PLEDGE AND CREED also appeared on the back cover of the final issue of the daily bulletin of the conference.

The hope that MY PLEDGE AND CREED will come into general use is also expressed by Dr. S. S. Goldwater, director, Mount Sinai Hospital, New York, N. Y., who says: "The pledge is a beautiful and dignified document, and I hope it will come into general use."

### The Pledge and Esprit de Corps

Mr. Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, Ill., comments upon the benefit which the Pledge and Creed will have upon the esprit de corps of hospital personnel. He says "I believe that liberal distribution of copies of MY PLEDGE AND CREED throughout our hospital will be of very great benefit in increasing interest among hospital people in their duties to the hospital and to the sick. I shall order a liberal supply of them and hang them where the employees and visitors can see them.

That the merit of MY PLEDGE AND CREED depends upon its practical value is implied by Miss Jessie F. Christie, R. N., superintendent, Chicago Lying-in Hospital and Dispensary, Chicago, Ill., who says: "My reaction to

MY PLEDGE AND CREED is an order for fifty copies which I intend to present to each one of our workers coming in direct contact with our patients.

Dr. C. W. Munger, director, Grasslands Hospital, Valhalla, N. Y., is another person who has shown his approval of MY PLEDGE AND CREED, by placing a large order for its immediate distribution throughout his hospital. Dr. Munger comments:

"I heartily approve of MY PLEDGE AND CREED. I am certain that its widespread use can have only the most salutary effect upon the attitude of hospital workers and upon the welfare of the patients whom they serve. A copy of this pledge before one's eyes daily should give one more pride in his work and should prevent him from

becoming mechanical or unsympathetic in working for the sick. I am ordering 275 copies for use in employees' rooms, as well as larger framed copies for department heads."

"If we can ever get our hospital workers imbued with such ideals," says Dr. B. A. Wilkes, superintendent, Missouri Baptist Sanitarium, St. Louis, Mo., in commenting upon MY PLEDGE AND CREED, "we will then be able to serve the sick people on a higher plain or level of usefulness than we have ever done before. I think so much of MY PLEDGE AND CREED that I am ordering thirty copies for use in my hospital."

The spiritual value of MY PLEDGE AND CREED makes a strong appeal to Miss Annette B. Cowles, R. N., superintendent, Children's Free Hospital, Louisville, Ky., who makes the follow-

ing comment: "I believe MY PLEDGE AND CREED is one of the most beautiful things we have had given to us. It is a pledge which needs to have reverent thought given to it and a creed that certainly demands the best that is in each and all of us. I shall endeavor to get several copies and have them framed and placed in various parts of the house. I cannot tell you how delighted I am to know that this spiritual background is being recognized as a necessity. We have had so much efficiency poured into our ears, that at the Milwaukee convention I was almost overwhelmed with it, and yet the main spring of it all is the better spiritual level. I sometimes wonder if, in our efforts to maintain highly organized institutions, we have not forgotten that unless we have the spirit behind it the work will be of little use."

"I believe that if everyone connected with a hospital, in any capacity whatsoever, would live up to the tenets included in MY PLEDGE AND CREED, these institutions would soon reach our highest ideals." This is the thought ex-

### My Pledge and Creed

"IN this connection I want to call your attention to MY PLEDGE AND CREED, recently published in THE MODERN HOSPITAL. This pledge and creed is the result of much thought—that is why it is so full of beautiful interpretation. I would like to see the spirit of this permeate all institutions. I wish MY PLEDGE AND CREED could be adopted and put into universal effect throughout every hospital in America. What a great change would come over many of our institutions! I would therefore recommend that the association take more interest in hospital ethics, establish a code of ethics, and adopt for universal use MY PLEDGE AND CREED."—Excerpt from the presidential address of Dr. M. T. MacEachern.

pressed by Dr. L. S. Schmitt, director, University of California Hospitals, San Francisco, Cal. "If the daily routine of the hospital simply reflects the sentiments expressed in this code of ethics," said Dr. Schmitt, "one can be assured that the hospital is consecrated to the greatest service that can be offered to humanity."

### Fulfills a Definite Need

That MY PLEDGE AND CREED fulfills a definite need in the way of a hospital code is the basis of the comment of Mr. Robert Jolly, superintendent, Baptist Hospital, Houston, Texas, who says: "I think it is high time someone wrote such a code. Other organizations and clubs have done so and it is right that we should have one. I have read MY PLEDGE AND CREED four times and am surprised to see how much has been expressed in 100 words. I am ordering a number of copies today which I will have framed and present to my associates."

Mr. J. B. Franklin, superintendent, Baylor Hospital, Dallas, Texas, expresses the widespread enthusiasm of many superintendents in his comment: "I am pleased with MY PLEDGE AND CREED and with your editorial accompanying it. In the first place, the paper is attractive in its design; the language is choice; the ideals expressed are broad and lofty; and the final effect is bound to be good. I shall place an order for several copies, and use them to the best advantage."

The Rev. N. E. Davis, corresponding secretary, Board of Hospitals and Homes, Methodist Episcopal Church, Chicago, Ill., expresses his appreciation of MY PLEDGE AND CREED thus: "Permit me to say that I compliment you on the subject matter, as well as the way it is set up. We will be glad to order further copies in case we have calls for them from this office."

The fitness of the pledge for hospital workers is the idea emphasized by Dr. K. H. Van Norman, superintendent, Charles T. Miller Hospital, St. Paul Minn., who says:

"We of the medical profession have the Hippocratic oath; and in this day and generation, with the advancement of ideas and ideals in the hospital field, it is most certainly fitting that hospital workers should have their pledge and creed."

"As for the pledge itself, you are to be congratulated on both the wording and the sentiment expressed throughout. Not only am I heartily in accord with your suggestion that MY PLEDGE AND CREED be in the possession of all the personnel, but I shall lose no time in putting the aforementioned suggestion into effect."

### A Reminder of Hospital Ideals

Dr. John D. Spellman, superintendent, Touro Infirmary, New Orleans, La., says: "I am favorably impressed with MY PLEDGE AND CREED and we shall immediately procure and frame sufficient copies to have one in each department of the institution. I am sure that every one of our personnel as well as the personnel of every other hospital is motivated by this very spirit but our difficulties

are in keeping our ideals in our minds throughout the trials that are inevitably met in the performance of routine duties."

The far-reaching effects of MY PLEDGE AND CREED are mentioned by Dr. W. P. Morrill, superintendent, Shreveport Charity Hospital, Shreveport, La., in his comment: "The formulation of such a creed cannot fail to have a far-reaching effect on the hospital world both by instilling higher ideals and devotion to duty in hospital personnel and by placing hospital workers before the public in their true light, as devoting their time and talents to the relief of suffering."

Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati, Ohio, points out that MY PLEDGE AND CREED embraces the essentials of hospital service, in his comment, "I am delighted with the sentiment pronounced in MY PLEDGE AND CREED. It seems to me that you have happily quoted the essentials of hospital service in this pledge and I believe it will receive a hearty welcome from the hospital field."

The effect MY PLEDGE AND CREED will have in promoting high morale among employees draws comment from Dr. Ernst P. Boas, medical director, Montefiore Hospital for Chronic Diseases, New York, N. Y., who says: "One of the most important features of a proper hospital organization is the establishment of a high morale among the employees and the realization by them that, in all contingencies, the patient and his needs have first claim on every unit of the hospital. I feel confident that the pledge which is presented by the editors of THE MODERN HOSPITAL will be of distinct help to hospital executives in establishing this spirit among their personnel."

"If all hospital workers were actuated by such high ethical ideals as are suggested in MY PLEDGE AND CREED, an enormous and desirable change would result," is the comment of Miss Carolyn E. Gray, R. N., formerly dean, school of

nursing, Western Reserve University, Cleveland, Ohio. She believes that it will serve as a reminder of the ideals of service. Dr. D. M. Morrill, director, Blodgett Memorial Hospital, Grand Rapids, Mich., says: "I believe this concise statement of a personal code which may be adopted by the entire personnel of our hospitals is a boon for which we have long been waiting."

The idea of moral responsibility which the Pledge and Creed embodies invites comment from Mr. Louis R. Curtis, vice-president, St. Luke's Hospital, Chicago, Ill., who says: "I am pleased to receive the copy of MY PLEDGE AND CREED and I think it is good. It presents in concrete form the obligations which any and all persons in hospital service should feel that they have assumed."

"There is, I regret to say, too little of the feeling of moral responsibility which rests, whether it is recognized or not, on every person connected with hospital work. Put in this concrete form the Pledge must help impress our people that they are not working by the day nor solely for money or education or experience."



## MY PLEDGE AND CREED

*REVERENTLY do I pledge myself to the whole-hearted service of those whose care is intrusted to this hospital.*

*TO THAT END I will ever strive for skill in the fulfillment of my duties holding secret whatsoever I may learn touching upon the lives of the sick.*

*I ACKNOWLEDGE the dignity of the cure of disease and the safeguarding of health in which no act is menial or inglorious.*

*I WILL WALK in upright faithfulness and obedience to those under whose guidance I am to work and I pray for patience, kindness and understanding in the holy ministry to broken bodies.*

## EXPOSITION UNPRECEDENTED IN QUALITY AND VARIETY OF EQUIPMENT

**T**HE twenty-sixth annual conference of the American Hospital Association presented an exposition of commodities used in every phase of hospital construction, equipment and operation, hitherto unprecedented in scope and variety.

The A. H. A. exposition has changed in character. The outstanding impression received from a thorough inspection of the exhibits was that instead of there being one display of a given commodity as in the past there were now several, thus giving the visitor to the convention an opportunity to form an opinion based on an inspection of similar commodities manufactured by different firms.

A second important aspect of the exposition was its educational phase. It is undoubtedly true that when we see pottery in the making; the process of gauze manufacture; when we have explained the various steps taken in the manufacture of some of the commodities that are used in the hospital, we realize to a greater degree the wide scope of the hospital field and the many factors that contribute to the efficient operation of our hospitals.

The arrangement of the exposition left little to be desired. The aisles were spacious and there was no congestion. Many of the concerns had their apparatus actually set up and in operation. When we stop to consider that the 106th Field Artillery Armory was devoid of all facilities required for this kind of a display and realize that electricity had to be brought in on a special line and that the lighting had to be separated, we cannot but marvel at the ingenuity and the energy that was put forth to make this convention a success.

The unfortunate illness of Dr. A. R. Warner, executive secretary of the association, placed a large part of the burden of the arrangement of the exposition hall on those not ordinarily expected to carry on this

work; consequently due recognition should be given to the untiring efforts of the executive committee of the Exhibitors' Association, to the office staff of the American Hospital Association, to Colonel William F. Schchl and Captain Edward E. Holden, who made the armory and its facilities available, and to the Buffalo Chamber of Commerce who lent ready and willing support toward making the convention a success.

In writing the story of the exposition from the standpoint of a hospital superintendent, it was thought best to discuss only those things that have an unusual appeal either by reason of their newness in the field, or because of their peculiar application to the present-day problems.

Furthermore, this account follows the six natural divisions of hospital purchasing which were adopted by the American Hospital Association in the planning of its annual exposition and in the appointment of special committees whose reports are presented at the annual conferences. These divisions are as follows: Section I, special construction materials, building equipment and supplies; section II, general furnishings, equipment and supplies; section III, clinical and scientific equipment and supplies; section IV, laundry equipment and supplies; section V, food service equipment, utensils and supplies; section VI, foods and beverages.

### SECTION I

#### Special Construction Materials, Building Equipment and Supplies

All of us have had more or less difficulty on account of action of chemicals on plumbing fixtures, especially in our laboratories. Not only is this true of the fixtures themselves, but also of the waste and supply lines serving these fixtures. One exhibit of the exposition offered a solution



View of the commercial exhibits which filled the drill hall of the armory. Aisles G and H are seen in the foreground.

of this problem in the form of ferrosilicon alloy pipe and pipe fitting which, to a great degree, resists the action of chemicals.

The flooring exhibits at this convention were entirely of the soft type. Undoubtedly there has been great progress in the development of better floors, for a marked improvement was noticeable in the products of the several concerns exhibiting flooring materials.

In the electrical field and its allied branches one of the new things was the installation of a radio jack with headpiece adjustment for use in private rooms, wards and nurses' call stations. Another new and desirable feature is a device for registering a call if the bedside cord becomes detached, thus guarding against severance of service caused by an accident in a room. In other words, the mere detaching of a cord either willingly or by accident registers a call at the central station.

Water purification and water treatment came in for their full share of attention.

Special lighting was fully discussed and demonstrated, and two very admirable solutions of the special lighting problems of the hospitals in operating rooms, delivery rooms and similar places, were displayed. The equipment shown was not limited to overhead lighting, but included special built-in fixtures for portable lighting, as well.

The exhibits of refrigerators, sound correction hospital hardware and plumbing fixtures were also interesting and instructive, although the latter line was not so generally represented as in the past.

## SECTION II

### General Furnishings, Equipment and Supplies

The development of steel furniture is becoming more and more universal and, with the advent of a steel finish that is durable (as demonstrated by several of the exhibitors) combined with less cost, this type of equipment should become increasingly popular. Steel chairs, bedside tables, case record cabinets, and in fact furniture for practically every use in a hospital was shown.

A durable finish for wood furniture, that carries with it an unusually attractive guarantee as to wearing quality was displayed.

The wheeled equipment of the hospital has been neglected in the past, but the present exposition shows that it has finally come into its own. This was evidenced by the marked improvement in the construction of casters. The particularly new things shown this year were several improved and more efficient caster locks.

A new bedside table, offering a combination service, was exhibited for the first time; also a bedside table making for increased rigidity, with a comparatively light aggregate weight was displayed.

Improved chart holders were shown this year, the variation from former types apparently adding to their efficiency.

Coincident with the improvement in floors comes improved methods for their care. Two of the exhibitors displayed floor finishes for which very attractive claims were made. One of the concerns also displayed a floor polisher which seems to be a decided improvement over other types.

Folding ladders and charts, while not particularly new, solve the problem of the institution which has little storage space.

## SECTION III

### Clinical and Scientific Equipment and Supplies

The educational phase of the exhibit in relation to clinical and scientific equipment was indeed marked. Practically all of the exhibitors are relying for their appeal, in a large measure, upon the opportunity to present innovations. Four concerns exhibited anesthesia apparatus. Aside from increased safety factors, which of course are each year becoming greater, the only thing particularly new in this line was a perfected system of piping gas from a central point, insuring a greater uniformity of control.

The use of ethylene for anesthesia is increasing in popularity and to meet the need for care in its handling one of the exhibitors showed equipment for ethylene control.

The treatment of disturbances of the respiratory tract by chlorine was demonstrated by one of the exhibitors.

The work of the American Hospital Association's committee on forms and records was illustrated graphically



A view of the exposition which gives an idea of its mammoth proportions.

by one of the exhibitors, and valuable suggestions on visible indexing and filing were brought to the attention of the delegates.

Gauze and its manufacture was shown in a way that made it of special educational interest. It was demonstrated that gauze, in being transformed from the raw state to the absorbent products used in hospitals, passes through thirty-nine different operations, fifteen of these processes being in the bleaching alone.

Special therapies, such as hydrotherapy, mechanotherapy and electrotherapy, are becoming more and more universally applied in our hospitals today, and to meet the needs thus created there were demonstrated a number of outstanding developments, one of which was pre-heater for quartz lamps, to reduce the time consumed in putting a lamp into operation and also to reduce possible damage to the lamp. The installation of pyrex shields between the lamp and the patient to insure against damage to the patient, if the lamp should explode, and the more efficient ventilation of the lamp, were features noted.

Portable units for electrotherapy were shown for the first time. In the x-ray field a water-cooled Coolidge tube and cooling system for modified deep therapy were displayed.

A model x-ray suite was shown which illustrated more graphically than could be done otherwise the desirable features of an x-ray department. Mention may be made also of a clinical camera with flood light attachment, that would seem to be valuable.

Portable x-ray units and an exceptionally flexible stereoscope for progressive study of special types of cases were among the high lights of the exposition.

Electrically controlled blankets for therapeutic purposes were offered for consideration.

A new microscope was submitted for the first time. It has a flexibility that has not been obtained with existing styles.

An indication of the rapid strides of occupational therapy in the hospital field is the growth in the number of organizations devoting themselves solely to the manufacture of equipment and supplies for this purpose. Some

of these are comparatively old, but a new contribution to the field of considerable interest was a set of supplies for the manufacture of brushes.

A new anesthesia container, with a drop attachment, was of unusual interest.

Recognizing that the problem of the care of bedpans has always been a very definite one, those interested in supplying this apparatus to hospitals have for years been trying to solve it. The contribution this year was a wall type bedpan washer and also an improved standard type of bedpan washer and sterilizer.

One of the exhibitors displayed a complete line of the fracture splints recommended by a committee of the American College of Surgeons.

A covered instrument tray, providing against contamination of instruments, was new and interesting.

An improved thermometer rack, providing for control of thermometers, and a thermometer shaker, designed to reduce breakage, arrested attention.

It is well known that one of the greatest difficulties with water bottles is the bulging and lack of adaptability to the patient's body. A new bottle with five contact points reinforcing its walls seemed to offer a solution of the problem.

An electric mouth illuminator, with easily detachable depressor, was exhibited.

Of particular interest to all in attendance were the improvements made in one of the standard types of bedpans.

There were also the usual exhibits of operating room tables, invalid lifters, fracture appliances, capes, and uniforms, teaching models, drugs, rubber sundries and general hospital supplies all of which attracted widespread attention.

## SECTION IV

### Laundry Supplies and Equipment

The laundry machine industry has awakened to the fact that the superheating of clothes in the drying process, incident to the old drying-room tumbler, was not beneficial, and the problem has been solved by two companies this year with an improved drying room tumbler, one with



Another view of the exposition. The model kitchen is seen on the left.

thermostatic control, and the other with a system of ventilating control that insures a lower temperature of the air.

A sterilizer-washer with many new features was also displayed, as well as a washer and extractor with all movable parts completely protected.

In addition to the exhibits of machinery for the laundry department of the hospital, soap, cleansing powders and sizing came in for their full share of attention.

### SECTION V

#### Kitchen Equipment, Utensils and Supplies

It has often been said that we people are like sheep. We were satisfied with the old style of can opener for many years. Then an improvement that was a real improvement came along; now there are several improved can openers, two of which were demonstrated at the exposition.

In dishwashers, the individual small washer for ward diet kitchens has been materially improved in the past year, and this was displayed by several concerns. An interesting thing about the dishwashing exhibits was the table arrangement recommended by the various firms.

The application of electricity in the solving of cooking problems, and the improvement in heating elements to insure a greater continuity of service, were graphically demonstrated.

A modified and improved gas burner that concentrated heat thereby offering a marked improvement, was submitted.

A complete line of Sheffield service plates and containers for tray service, that could be heated, was displayed.

A kitchen machine equipped with an ice crusher, cubing attachment, etc., was an improvement over that shown last year.

A recognition of the desirability of supplementing personnel in the kitchen with as much mechanical equipment as is possible was indicated by a very inclusive ex-

hibit of such things as mechanical slicers, toasters, cutting machine. A complete baking outfit, including flour and dough mixers, made an interesting exhibit.

The educational exhibit of a china manufacturer was well worth while. The development of paper tray covers, napkins, and cups was particularly interesting.

By far the most popular exhibit and the one that probably did the greatest amount of good, was the model kitchen, depicting the actual equipment desirable for a seventy-five bed hospital kitchen. The time and energy expended by the exhibitors in submitting this exhibit to the convention is worthy of sincere commendation.

### SECTION VI

#### Foods and Beverages

The largest item of supply expense in the hospital is undoubtedly that for food stuffs, and there probably is no one class of commodities that has more direct bearing on the formulation of public opinion and the building of good will for the institution than does the dietary service of the hospital. That this has been increasingly recognized was indicated by the large variety of exhibits limiting themselves exclusively to food stuffs.

In addition to the general run of complete lines of canned goods, both vegetables and fruit, that have been exhibited for a number of years, there were in evidence this year several innovations, such as dehydrated fruit powders for jelly purposes, the preparation of sugar free desserts, the food value of gelatin in conjunction with other food products in the preparation of palatable and scientifically created foods. There were also some interesting demonstrations of products for the modification of milk that are easily adaptable to nutritive use. All in all the exhibits of food products were unusually attractive.

A hospital superintendent at the Buffalo conference raised the question of the advisability of discontinuing the term "superintendent," and replacing it by some uniform term such as "administrator."



The exposition looking toward the entrance to the armory.

## PUBLICITY SERVICE A CENTER OF INTEREST AT NATIONAL HOSPITAL DAY BOOTH

A new feature added to the exposition at the Buffalo conference was the National Hospital Day Booth provided by the association. Mr. Ralph Welles Keeler, New York City, Counsellor in Publicity of the Board of Hospitals and Homes of the Methodist Episcopal Church, was in charge of this booth.

An exhibit had been prepared showing that many of the hospitals did in the way of publicity for National Hospital Day in 1924. There was also a large chart giving suggestions for the observance of the day next year.

Mr. Keeler kept office hours at the booth where hospital superintendents and others came for advice on their local publicity problems. Men and women from practically every state and province brought real problems and received detailed counsel as to how to work them out. Many asked for further advice and will write for more detailed information. Practically everyone who consulted Mr. Keeler expressed great appreciation of his series of articles on publicity which have been appearing in *THE MODERN HOSPITAL* since May, 1923.

In connection with his work of advising on individual local publicity problems, Mr. Keeler held two publicity breakfasts at the Statler Hotel. The first on hospital publicity in the newspaper was attended by thirty-one hospital superintendents, each of whom entered into the round-table discussion with a great deal of enthusiasm. The second breakfast clinic was on leaflet literature and the annual report. Thirty-five persons were present and were given the opportunity to exchange their experience and ideas and to hear what the leader of the clinic had to say. There seemed to be a general impression that this new venture of the American Hospital Association is an exceptionally practical affair. Hospital executives are looking forward to even greater service through the National Hospital Day committee.



Mr. Ralph Welles Keeler, whose publicity service proved a popular center of interest at the conference.

## OCCUPATIONAL THERAPY EXHIBIT MOST EXTENSIVE IN HISTORY

One of the outstanding features of the eighth meeting of the American Occupational Therapy Association, was the largest and most valuable exhibition ever presented by the association. This exhibit consisted of the visible results of the many activities in which patients were employed in the departments directed by the various therapists, members of this association.

To one who has carefully studied the development of occupational therapy from the time that the first pioneers, more than one hundred years ago, conceived the idea that work had a curative value, to the present revival of the work, which really had its beginning about thirty-five years ago, this exhibit was an open book from which many things are read.

The general tone of the exhibit was better than usual and this was also true of the units composing the whole.

It was generally conceded that wherever color entered into the object, it was good. This could never be so all-inclusively said of any preceding exhibit. There was a very noticeable improvement in the texture of fabrics of every description. Design which enters so largely into every phase of craftwork showed more real purposeful thought and originality. One missed, in a way that was most gratifying, the type of design which seemed to be applied without thought to any and every piece of work. Lastly, there was a noticeable improvement in general craftsmanship which is evidence of the rehabilitative value of the work.

The standards attained as shown by the workmanship displayed are the results of cooperation of the workers and the vision which this closer relationship has inspired. That the standard of excellence observed is now far-reaching was shown by the work of the following institutions contributing to the exhibit.

Home for Destitute Crippled Children, Chicago, Ill.; Medical Work Shop, Marblehead, Mass.; Robert Breck Brigham Hospital, Boston, Mass.; Baltimore Craft School, Baltimore, Md.; Vermont State Hospital, Waterbury, Vt.; Presbyterian Hospital, Chicago, Ill.; Wesley Memorial Hospital, Chicago, Ill.; Association for the Crippled and Disabled, Cleveland, Ohio; Kalamazoo State Hospital, Kalamazoo, Mich.; Snow-Abbott Looms, 65 E. 56th St., New York, N. Y.; Howell State Tuberculosis Hospital, Howell, Mich.; Grace Hospital, Detroit, Mich.; Eloise State Hospital, Eloise, Mich.; Detroit Tuberculosis Hospital, Detroit, Mich.; National Military Home, Milwaukee, Wis.; Marion National Sanatorium, Marion, Ind.; National Soldiers' Home, Sawtelle, Cal.; National Soldiers' Home, Johnson City, Tenn.; National Soldiers' Home, Central Branch, Dayton, Ohio; Battle Mt. Sanitarium, Hot Springs, S. D.; Sheppard-Enoch Pratt Hospital, Baltimore, Md.

The following Minnesota hospitals contributed:

Phalen Park, St. Paul; Ancker Hospital, St. Paul; Mayo Clinic, Rochester; Glen Lake Sanatorium, Oak Terrace; Fergus Falls State Hospital, Fergus Falls; U. S. Veterans' Bureau, Minneapolis; Rochester State Hospital, Rochester; Riverside Sanatorium.

Pennsylvania hospitals exhibiting were:

Philadelphia Hospital for Mental Diseases, Philadelphia; Pennsylvania State Department of Welfare, Harrisburg; Harrisburg State Hospital, Harrisburg; Homeopathic State Hospital, Allentown; Danville State Hospital, Danville; Retreat Mental Hospital, Retreat; Pennsylvania Hospital, Philadelphia; Philadelphia General Hospital, Mayville.

The following New York institutions were represented:

Buffalo State Hospital, Buffalo; Willard State Hospital, Willard; King's Park State Hospital, King's Park; King's Park Veterans' Bureau, King's Park; St. Lawrence State Hospital, St. Lawrence; Brooklyn State Hospital, Brooklyn; Hudson River State Hospital, Poughkeepsie; Binghamton State Hospital, Binghamton; Central Islip State Hospital, Central Islip; Gowanda State Hospital, Helmuth; Bloomingdale Hospital, White Plains; Vanderbilt Clinic, New York City; Bellevue Hospital, New York City; Montefiore Hospital, New York City; Grasslands Hospital, Valhalla; Loomis Sanatorium, Liberty; and Buffalo City Hospital, Buffalo.

## EXHIBIT OF HOSPITAL LIBRARY POPULAR CENTER OF INTEREST

The exhibit of the Hospital Library and Service Bureau was on a larger scale than ever before and attracted many visitors throughout the conference. The booth was gay with the color lent by the flags of fourteen countries all of which have been served by the bureau, an indication that its activities reach far and wide.

The director of the bureau, Miss Donelda R. Hamlin, Chicago, Ill., gave unstintedly of her time and energy to the many superintendents, representatives of building committees, hospital architects and others who claimed her assistance in their study of the floor plans, package libraries, bibliographies and other material at their service through this exhibit.

One-half of the exhibit was devoted to hospital construction material, and here over 700 floor plans of hospitals, sanatoriums, nurses' homes and allied institutions were displayed, conveniently arranged and classified. Supplementing these plans were a number of package libraries covering the subject of hospital construction in its relation to general hospitals and also to special hos-

pitals, such as children's, maternity and isolation hospitals.

Another angle of the exhibit was the presentation of the mass of data on matters of hospital organization and operation. This has been assembled by the bureau and was here at the service of delegates for their perusal, thereby enabling them to judge the comprehensive nature of the service which the bureau offers through its package libraries of which it has 200.

A list of subjects on which bibliographies have been compiled could be consulted and there were sample copies of the new printed bibliographies, now four in number and soon to be followed by others. There were shown also sample month's indices of all of the hospital journals.

An interesting chart showed the geographical sources of inquiries received by the bureau which have come from every state in the union and from over twenty foreign countries.

Another feature was the exhibit of pictures of Buffalo hospitals, accompanied by a historical statement about each institution, and also a statement calling attention to special features worthy of note in individual hospitals in the city.

This idea of showing photographic views of local hospitals and preparing a list of noteworthy features in individual institutions for the benefit of delegates is one which will be carried out at future conventions, and after the convention the material will be assembled in scrap-book form and will become a permanent part of the bureau's files.

### DISPENSARY BOOTHS FORM MART FOR EXCHANGE OF IDEAS

Exchange of ideas by dispensary representatives from various parts of the country, representing a marked variety of activities, was one of the most important activities of the dispensary booths.

"How do you estimate cost per visit?" "Is the post-card or letter system of follow-up successful?" "Who should be responsible for the medical distribution of new patients? How is it done?" "What is the average rate of payment to the doctor for dispensary service?"

The type of questions asked and the sincerity and eagerness with which they were discussed, indicate not only the growing importance of dispensaries but the degree of careful thought that is going into their organization and administration. Each year, according to the booth attendants, the reports of new dispensaries established, the intelligence and scope of the discussions of dispensary problems, marks a distinct advance in this important field. The number of visitors this year, representing trustees, physicians, executives, social service workers, nurses, is considerably larger than any previous year.

The booths assigned to the dispensary exhibits provided admirably for the display of charts and exhibits at the same time providing space for group conferences. The charts, executed strikingly in black and white with silhouetted figures, covered a few carefully selected topics, chosen primarily in an effort to promote discussion. Those depicting the order created out of chaos of one dispensary's admitting system, through a study and re-directing of the traffic lanes, attracted the widest attention.

Several hundred reports on "Principles of Records and Record Keeping" prepared by the superintendent's section of the Associated Out-Patient Clinics, reprinted from THE MODERN HOSPITAL, were distributed. The analysis

of the steps involved in admitting a patient, entitled "The Trail the Patient Travels from the Door to the Doctor," was also distributed in large numbers. Many requests for material to be mailed on appointments, follow-up systems, fees, accounting and other reports were recorded in the register. The hospital map of New York City, prepared by the United Hospital Fund, and the financial statistics sheet of this fund also aroused interest and mailing orders were taken for both.

Mr. Michael M. Davis, Jr., executive secretary, Committee on Dispensary Development, New York, N. Y., Dr. Alec N. Thomson, medical secretary, Committee on Dispensary Development, and Miss Janet M. Geister, R.N., research worker, Committee on Dispensary Development, were in attendance at the dispensary booths.

### AMERICAN HEART ASSOCIATION EXHIBIT SHOWS NEED OF CARDIAC CARE

The exhibit of the American Heart Association, Inc., was planned to give prominence to the value of organized care for cardiacs from a hospital standpoint, to show the national trend of the work being done along this line and where such work has been started, to show how inadequate is still the provision for the care of those suffering from heart disease.

These points were clearly brought out by the charts displayed in the booth. Of special value was the chart giving a suggested plan of organization for a heart clinic, showing the cooperation of departments necessary in such a clinic. This plan was designed to embody general principles to be followed in organizing a heart clinic, and hospital superintendents can modify and adapt it to the needs of an individual hospital or community.

The chart on organized care of heart disease brought out the value of such care to the patient, to the community, to preventive work, to the hospital and to the physician.

A number of photographs showed the vocational guidance side of the organization, which is developed for the benefit of young sufferers from heart disease. In the schools where this work is carried on girls are taught such things as millinery and dressmaking and boys' drafting, radio work and typewriter repairing.

Bulletins from local branches of the association were distributed as well as folders descriptive of the many-sided activities of this national association.

### CHILD WELFARE ASSOCIATION FEATURES EXHIBIT OF EDUCATIONAL POSTERS

Superintendents, heads of departments, and nurses were continually grouped around the booth of the National Child Welfare Association to study its posters.

"Fine for the children's wards and playrooms! We have a children's department,—orthopedic and medical,—and I want something decorative, something to interest them. The children grow restless as they're getting well. Here, some of these Fairy Tales, and things like this!"

The visitor was pointing to a decorative series, set frieze-wise, of food rhymes; another of children in the bright quaint costumes of their native lands; and a varied assortment of health rhymes after the fashion of Mother Goose. Thus the selection was made from the different health habits series, gay with pictures and blithe with rhymes, and pointed with common sense and humor.

This exhibit was testimony that the idea of poster instruction is growing with repeated proof that a good poster, may be of help to the whole staff.

## PROGRESS MARKS FOURTH CONVENTION OF PROTESTANT HOSPITAL ASSOCIATION

**T**HE fourth convention of the American Protestant Hospital Association, held at Buffalo, N. Y., October 4-6, marked several important steps of progress in association work and in the material development of its hospitals, since during the past four years Protestant hospitals have added forty million dollars to their property holdings, and more than 100 have joined the ranks of those in the list of accredited hospitals reaching the minimum standard. The reports of membership and other activities indicated progress. A valuable program was presented, and the discussion of subjects indicated the intelligent and keen interest of the delegates.

### Summarizes Aims of Association

Dr. C. S. Woods, superintendent, Saint Luke's Hospital, Cleveland, Ohio, president of the association, sounded the keynote in his address, when he declared the purpose of the Protestant hospitals to fulfill the mission for which they were organized; to lift the standard of equipment and service; to seek standardization of every hospital not already included in the list; to spare no pains, expense or sacrifice in satisfying the requirements of the patient in the hospital. He pointed out the benefit of united effort in constructive endeavor and made it clear that a healthy growth is marked by evenness and persistency of application and a definite understanding of principles.

The executive secretary's report showed an increase in membership. Notwithstanding conservative declarations of activities, it was apparent that a large scope of work has been covered. National and state committees were constituted to meet the requirements laid down by the Protestant hospitals. The association will seek to improve conditions relative to inheritance taxes on bequests for charitable institutions. It was asserted that large sums are annually diverted from these institutions and used for state purposes, making the conduct of such institutions increasingly difficult. It was reported that the church and charitable institutions in one state lost one million dollars in one year on account of the state tax on their bequests.

### Emphasizes Need for Publicity

"Publicity for Hospitals in the Literature of the Church" was handled by Dr. Arch C. Cree, general superintendent, Georgia Baptist Hospital, Atlanta, Ga. "Make the name of your hospital stick in the minds of the people and you have accomplished an advertising victory," he

declared. "When you reach the point when the mere mention of the name of your institution wins an immediate recognition and response in the territory of your constituency you are 100 per cent on this point."

Miss Margaret A. Rogers, superintendent, Children's Hospital, Detroit, Mich., presented a study of "The Relation of the Environment of the Nurse to Her Work," in which she maintained that one of the most marked changes which has occurred in hospitals in the past twenty years was the extreme youth of the student who now enters the school of nursing. The change in the age limit from twenty-three to eighteen has made it necessary for the hospitals to adopt an entirely new policy regarding the care of the student during her training."

Mr. L. G. Reynolds, superintendent, Methodist Hospital, Los Angeles, Cal., declared that the three-year period for

the nurses' training school should not be made shorter simply to induce girls to take the course. He would advise every prospective student nurse not to enter training until an inner urge simply compels her to enter. "Lifting the standards and not lowering them will bring the necessary numbers to our schools."

By unanimous vote the association went on record as standing for a full three-year course of training for student nurses.

"Hospital and Institutional Construction" was the subject of a paper read by Mr. Charles S. Pitcher, superintendent, Presbyterian Hospital, Philadelphia, Pa. Mr. Pitcher, held that experience, good judgment, tact, perseverance and a determination to see it through were necessary elements in planning and consummation. He stated that the location of a hospital determines the type

of construction and material used and that each group of hospital workers should have opportunity to present their needs and these should be carefully considered in conferences, so that a comprehensive plan may be developed which will cover the requirements of all departments.

In a paper on "Hospital Accounting," Mr. Jos. F. Miller, superintendent, Methodist Hospital, Peoria, Ill., said that as every hospital accountant thinks his system the best, he would not offer a system but would present a study of principles. He believes that public and charitable institutions would have better talking points if they would state cost values rather than appraisal values of property. Every item of depreciation, sinking fund, accounts and notes receivable, cash and bank accounts are collected and filed daily so that it is possible to know



Three workers in the Protestant hospital field: Miss Ingeborg Sponland, superintendent, Lutheran Deaconess' Hospital, Chicago, Ill., and Sister Nellie Oleson, of the same hospital, and Miss Mathilda Hoem.

the standing of the institution at the close of any day.

Mr. Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, Ill., in a paper "Nursing Middle Class People," brought out that the training of so-called nurses' aides, practical nurses, the training for home nursing and many other schemes have all failed, because these two classes cannot be controlled by law or otherwise, after they have finished their course of training. He advocated as the remedy, the placing of missionary trained nurses in the community, to care for the sick who do not want charity, and can only pay a part of the cost of a registered nurse. This, he thinks, will solve the problem and make the church a much stronger community factor.

#### Describes Community Chest Work

Mr. Raymond Clapp, associate director, Cleveland Welfare Federation, Cleveland, Ohio, pointed out, in his address, that the community fund plan for the joint financing of social agencies, as a development of the past ten or fifteen years, has spread until the plan has been adopted in over two hundred American cities.

"The Church's Share of the Burden of the Sick" was the subject of an address by the Rev. H. L. Fritschel, superintendent, Milwaukee Hospital, Milwaukee, Wis., who asserted that in hospitals established, maintained and governed by the church, the ideals for which the church stands can be cultivated more fully.

#### Simple and Accessible Equipment

Mr. Robert Jolly, superintendent, Baptist Hospital, Houston, Texas, in his paper on "Hospital Equipment and its Arrangement," used his own new hospital for illustrations. "Of course surgical and x-ray and scientific equipment are not all of the hospital," said Mr. Jolly, "and it behooves us to see that, beginning at the front door and ending on the roof, each piece of equipment or each department of the hospital is located to economize time and skill. I think a good motto would be 'simplicity and accessibility,' as the goal. It's up to you to make the equipment fit your particular case."

"The Henry Ford Hospital Organization and Policy" was the subject of a paper by Mr. W. L. Graham, superintendent of that institution. It was apparent from his discussion that the Henry Ford Hospital has many distinctive features some of which are: Patients are in buildings remote from the noise of the boulevard; twenty-six interns are appointed annually; the staff comprises 100 doctors, all full-time men; a clinical pathological conference is held every Friday afternoon; specialized training is afforded doctors who are released to the community at large; the diagnostic clinic determines whether the patient should be admitted to the hospital; standard charges are made for all services.

Mr. Clarence W. Williams, Deaconess Hospital, Boston, Mass., brought "Modern Conceptions of Hospital Architecture" to the attention of the association. He said: "If I were about to advise you regarding a thoroughly up-to-date hospital and its equipment, I should, in the first place, visit the location of the contemplated building or buildings; I should need to know the surroundings, points of compass, the class of people you would serve, a residential or manufacturing center, the extent of wealthy, middle class and poor people.

The conference on "The Ethical and Spiritual Relations of the Nurse," conducted by Miss Meta Pennock, editor, *The Trained Nurse and Hospital Review*, revealed the importance of better conditions in the interests of better schools of nursing. "The profession has no higher ambition," said Miss Pennock, "than the highest standard

of character and service. It is the duty of the church to motivate all her actions and safeguard every girl in her chosen life service."

#### Preparation for Administrative Work

Mr. E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago, Ill., and president-elect of the American Hospital Association, came to the convention in its closing hours with a discussion of "Preparation for Administrative Work in Hospitals." He contrasted the medical or nurse superintendent spending years in acquiring information in one branch only, with the layman acquiring his knowledge of hospital administration in the "rugged and ragged" school of experience. Mr. Gilmore made a plea for "a university that would carry instruction in medicine, nursing, engineering, architecture, law and commerce, each one of these subjects to be studied in all of its relations to hospital activities—not exhaustively, but comprehensively. This would raise hospital superintendency to the rank of a profession. The reason which should impel a university to include such instruction in its curriculum is that thereby it would better equip men for the work which is essential for the advancement of society."

#### Publicity Value of Bulletins

"The Issuing of Hospital Bulletins" was discussed in a paper read by Mr. C. J. Cummings, superintendent, Tacoma General Hospital, Tacoma, Wash. "We may have the best of hospital facilities and service, but we need to be able to tell its story so well that others will know," he declared. "Bulletins have proven their value in making friends for the hospital and it is to the credit of the Protestant Hospital Association that this group was the first to bring the subject of hospital bulletins before an annual convention.

Dr. N. E. Davis filled the only vacancy in the program by giving an extemporaneous address on the subject of "Raising Money for Hospitals." His address was based on his experience as corresponding secretary, Board of Hospitals and Homes of the Methodist Episcopal Church. He believes that no hospital should be permitted to make a financial campaign without the proper authorities first making a thorough investigation of the need, the resources and the time. Whether it be a city, a private, or a church hospital or institution of mercy, it should be authorized by the responsible authorities of the city or church or an organized board.

There were twenty-nine states represented in this convention and the hospital representatives present decided that this was the best program yet undertaken. The very finest of fellowship was enjoyed at the banquet and social gatherings.

The following officers were elected for the coming year: President, Dr. Newton E. Davis, corresponding secretary, The Board of Hospitals and Homes of the Methodist Episcopal Church, Chicago, Ill.; vice-president, Dr. A. O. Fonkalsrud, superintendent Lutheran Hospital, Sioux Falls, S. Dak.; executive secretary-treasurer, Dr. Frank C. English, St. Luke's Hospital, Cleveland, Ohio. The trustees are Miss Mary F. Dever, superintendent Methodist Hospital, St. Joseph, Mo.; Dr. Arch C. Cree, general superintendent, Baptist Hospital, Atlanta, Ga.; Dr. B. A. Wilkes, superintendent, Baptist Sanitarium, St. Louis, Mo. The executive committee consists of Dr. Charles S. Woods, superintendent, St. Luke's Hospital, Cleveland, O.; the Rev. Thomas A. Hyde, superintendent Christ Hospital, Jersey City, N. J.; Miss Mable Woods, superintendent State M. E. Hospital, Mitchell, S. Dak.; and Mr. Robert Jolly, superintendent, Baptist Hospital, Houston, Texas.

## EIGHTH MEETING OF AMERICAN OCCUPATIONAL THERAPISTS EXCELS FORMER CONFERENCES

THE eighth annual meeting of the American Occupational Therapy Association opened at Buffalo, N. Y., October 7 with a large attendance of members. The exhibit of patients' work from hospitals was one of the largest and most comprehensive that has ever been assembled. The high degree of skill evidenced by the quality of the products and the wide variety of arts and crafts work attracted large crowds of visitors.

At the opening session a further installment of the valuable report on equipment and materials was presented by the committee on installations and advice, under the chairmanship of Miss Harriet A. Robeson, King's Park State Hospital, Kings Park, N. Y. The report of the standing committee on publicity and publications was presented by Dr. W. R. Dunton, Jr., Baltimore, Md., chairman, who told of the increasing activities during the past year. The report of the finance committee dealt with the efforts that are being made to increase the income of the association, in order that its usefulness may be increased and its scope of national service broadened and developed.

The report of the secretary-treasurer, Mrs. Eleanor Clarke Slagle, New York, N. Y., showed a large increase in membership during the year, the total number of members in good standing being about 700. The placement service is growing and about 100 persons have been nominated for positions since the last annual meeting. The advisory service to hospital and sanatorium authorities on all matters relating to occupational therapy has been called upon to an increasing extent during the year. In addition to requests for advice from many institutions and hospital authorities in this country, numerous requests have been received from abroad, including England, China, New Zealand and India. There has also been a large increase in the number of requests for personal advice from individuals, and many members and others have been greatly helped by this branch of the advisory service.

The standard forms and records adopted by the association at the last annual meeting have been widely adopted in hospitals in the United States, and other countries, including one hospital in India.

The minimum standards of training for occupational therapists adopted at the 1923 meeting have been met by all the leading training schools.

The board of management presented an increased budget for the coming year, which met with the hearty approval of the members.

A special vote of thanks was given to secretary-treasurer, Mrs. Eleanor Clarke Slagle, for her great service.

A special committee, under the chairmanship of Mrs. Doris Dale Wood, president of the Illinois Association of Occupational Therapists, presented a report on a model constitution and by-laws for state and local associations.

A preliminary report was also submitted by a special committee under the chairmanship of Dr. W. R. Dunton, Jr., on a syllabus of lectures to interns and nurses on occupational therapy.

The public opening on Tuesday afternoon, October 7, attracted a large audience. After an invocation by the Rev. Richard H. Boynton, Buffalo, an address of welcome was given by the Hon. Frank X. Schwab, mayor of Buffalo.

The president, Mr. Thomas Bessell Kidner, institutional

secretary, National Tuberculosis Association, New York, N. Y., then gave his address, in which he outlined some of the notable advances in the work of the association during the past year, emphasizing the need for various extensions of the work of the association which could be undertaken, were funds available. While the membership is growing, a much larger membership should be arrived at and every occupational therapist should support the association and thus make possible an enlargement of the service it is now able to render to the work and to the members themselves.

The report also pointed out the necessity for thorough training of workers, and urged that members should direct all candidates for training to one of the regular training schools or courses. While many of the inadequate short courses have been discontinued, there are still to be found institutions that offer so-called occupational therapy courses that do not even remotely approach the

minimum standards of training.

The further development of state and local associations was suggested as most desirable and to assist in this a committee will undertake the preparation of a model or standard program of desirable activities for such associations to be presented at the next annual meeting.

The establishment of a national roster of qualified workers has not yet been possible, Mr. Kidner pointed out, but must be undertaken in the near future.

There is need for short, intensive courses of post-graduate type, both in theoretical and practical work for occupational therapists who desire to improve their professional qualifications and the quality of their service.

Mr. Kidner also referred to the increasing value to all engaged in occupational therapy, of the organ of the association, the *Archives of Occupational Therapy*.

Members were also urged to keep in touch with related fields of endeavor. It cannot be too often insisted that, valuable and indeed indispensable as it is in the scheme of



Two leaders in the occupational therapy field: (Left) Mr. T. B. Kidner, president, American Occupational Therapy Association, New York, N. Y., and Dr. W. Rush Dunton, Baltimore, Md.

rehabilitation of a sick person, occupational therapy is only one part in the progress of a sick or disabled person from his or her bed in a hospital, back to useful work in the world. While it is necessary that occupational therapists should be well-grounded in their knowledge of the medical aspects of their work, it is of equal importance that they shall be acquainted with the work of other agencies concerned in the end-result, which is, the restoration of the patient to health and usefulness.

He thus emphasizes that it is necessary, for occupational therapists to be continually on the alert to meet the changing needs which are so characteristic of medical and social work today, but at the same time to maintain strongly their faith and belief that the work in which they are engaged is primarily therapeutic, although in some cases it may have some secondary value as pre-vocational or pre-industrial training.

### Predicts Great Field of Usefulness

In closing, Mr. Kidner expressed his belief that while the association in its seven and a half years of existence has accomplished much, it has a great field of usefulness before it, and that in the future it can play an even more important part in the development of curative work than it has in the past.

The prophecy can, however, be fulfilled only if every member realizes his or her personal responsibility for the continued development of the work, and for the upbuilding of a loyal, cohesive body of workers under the guidance of the American Occupational Therapy Association.

Dr. G. Canby Robinson, vice-president, was unable to be present owing to his duties in connection with the opening of the Vanderbilt Hospital at Nashville, Tenn., but sent his paper on "The Relation of Occupational Therapy to Medicine," which was read by the secretary-treasurer, at Dr. Robinson's request.

The afternoon session was concluded by an address by Mr. Arthur J. Walliston, a member of the board of directors of the Boston School of Occupational Therapy, and formerly president of the Wentworth Institute, in which he pointed out some of the limitations as well as the great possibilities of curative work.

The evening session on October 7 was devoted entirely to the subject of training occupational therapists. Encouraging reports showing a large enrollment in the following schools—Boston, Mass.; Philadelphia, Pa.; Detroit, Mich.; Kalamazoo State Hospital, Kalamazoo, Mich.; St. Louis, Mo.; Milwaukee-Downer College, Milwaukee, Wis.; Fondren (State Hospital), Miss.

An active round-table discussion on the subject was then held under the chairmanship of Miss Geraldine Lermitt of the Missouri School of Occupational Therapy, St. Louis, Mo. The leaders were Miss Florence Fulton, Philadelphia School of Occupational Therapy, Miss Edith Sullivan, Newberry House, Detroit, Mich., and Miss Marjorie Green, Boston School of Occupational Therapy, Boston, Mass.

Wednesday morning's session was devoted to occupational therapy in tuberculosis. The opening paper was by Dr. H. A. Pattison, director of medical service, National Tuberculosis Association, on "Occupational Therapy in Relation to Economic Independence." Speaking from his wide experience in tuberculosis, and as a thorough believer in the value of occupational therapy, Dr. Pattison pointed out that personality is as important as proper training for every person who deals with the sick. He urged, also, that for the sake of the many smaller sanatoriums very simple work involving a minimum of ex-

penditure for equipment and materials, should be selected. Nature study, he stated, may also be an exceedingly valuable form of occupation for tuberculous patients in a sanatorium, and this work requires practically no special equipment.

Colonel James E. Miller, medical director, Veterans' Bureau Hospital, Oteen, N. C., presented a paper entitled "Observations on Occupational Therapy in a Veterans' Bureau Hospital." The various types of work that had been found suitable for patients in different stages of tuberculosis were described and the possibilities of pre-vocational value as a secondary result of therapeutic occupation were also pointed out, but Colonel Miller's paper also bore testimony to the excellent effect of occupational therapy on the morale of a hospital.

A round-table discussion, presided over by Miss Beatrice Lindberg, director of occupational therapy, Minnesota Tuberculosis Commission, with Dr. H. A. Pattison as medical moderator, proved most interesting and valuable.

### Honored by State Hospital Commission

The fifth session was held on Wednesday afternoon, October 8, in the assembly hall of the Buffalo State Hospital, when the association was honored by the presence of the State Hospital Commission and the medical superintendent of all the hospitals under the jurisdiction of the commission.

An address of welcome by the medical superintendent of the hospital, Dr. Frederick W. Parsons, was followed by an inspiring address by Miss Harriet May Mills, member of the commission, on "Observations on Occupational Therapy in New York State Hospitals."

"The Development of the State-Wide Program of Rehabilitation for Mental and Nervous Patients" was the subject of an address by Dr. C. Floyd Haviland, chairman, State Hospital Commission, who presented figures relative to the growth of occupational therapy in the New York state hospital system during the past two years, under the directorship of Mrs. Eleanor Clarke Slagle, to whom both Miss Mills and Dr. Howland paid high tribute for her work.

Dr. Earl C. Bond, Pennsylvania Hospital, gave a historical review of "The Development of Occupational Therapy for Mental and Nervous Diseases." "Occupational Therapy in an Indian Hospital" was the subject of a paper (read by title) by Dr. Owen Berkeley Hill, European Mental Hospital, Ranchi, British India.

A film showing the work in the Manhattan State Hospital, New York, N. Y., was an interesting feature of the meeting.

The round-table discussion included a variety of practical topics. Miss Harriet A. Robeson, Kings Park State Hospital, Kings Park, N. Y., presided, and Dr. E. C. Noble, Boston Psychopathic Hospital, Boston, Mass., was medical moderator.

The session concluded with the serving of afternoon tea to the members and guests by the chief occupational therapists of the New York State Hospital system.

### Brings Greetings from Canadian Workers

The annual banquet on Wednesday evening was attended by over 200 persons, including a number of Canadian occupational therapists. The principal guest of honor was Dr. Goldwin W. Howland, department of public welfare, Toronto, Ont., who carried the greetings of Canadian occupational therapists to their fellow workers in the United States. In a speech alternately humorous and serious, Dr. Howland told of the development of occupa-

tional therapy in Canada, and especially of the "central workshops" which have been established for post-hospital cases in Toronto and other centers.

Mr. R. K. Atkinson, director of recreations and physical exercises, Russell Sage Foundation, New York, N. Y., once again delighted the members of the association with an address on the value of the play spirit in curative work, and the necessity for cooperation and a whole-souled enthusiasm in all work for the sick and disabled.

Colonel B. F. Hayden, chief surgeon, National Military Home, Dayton, Ohio, outlined in an address the comprehensive nature of curative work established in the various hospitals in the National Home system for veterans of the world war. An address was also given by Miss Edith Stedman, director of occupational therapy, American Church Mission Hospital, Wu-Chung, China. Mrs. Eleanor Clarke Slagle, who was one of the founders of the association closed the evening with some reminiscences of the early years of her work in occupational therapy.

Thursday morning's session was given over to visits to hospitals and an excursion to Niagara Falls. A large number of members motored to Perrysburg to visit the J. N. Adams Memorial Hospital, where Dr. La Grasso, medical director, received the visitors and explained the technique and value of heliotherapy as it is applied in this remarkable institution.

The afternoon and evening sessions were devoted to occupational therapy in general medical, surgical and orthopedic cases.

The principal feature of the afternoon session was an illustrated lecture on "The Orthopedic Patient Crippled by Disease" given jointly by Dr. Lewis Spear and Miss Marjorie Taylor, both of the Robert Breck Brigham Hospital, Boston, Mass. In a fine series of slides a large number of arthritic cases were shown undergoing treatment by occupational therapy. Dr. Spear explained the medical feature of each case, and

Miss Taylor gave an account of the various steps taken to restore impaired joint functions by means of a great variety of simple appliances and elementary occupations, calling for carefully graduated effort on the part of the patients.

"Work for the Home-Bound," an account of Cleveland's work for crippled and disabled persons outside hospitals, was presented by Miss Selma Sullivan.

The difficulties of organizing and applying occupational therapy in a mission hospital in China were related in an instructive paper by Miss Edith Stedman, American Church Mission Hospital, Wu-Chung, China.

"Occupational Therapy in the Mayo Clinic" by Miss Beatrice Hardy, Worrell Hospital, Rochester, Minn., was an account of the application of curative work in a comparatively new field.

Miss Marion Clark, University Hospital, Ann Arbor, Mich., gave a clear and detailed description of the occupational therapy work for children suffering from all sorts of ailments in the occupational therapy center of the university hospital.

A valuable paper was given by Dr. B. W. Carr, chief of the division of physiotherapy and occupational therapy, U. S. Veterans' Bureau, Washington, D. C., on "The Value of Occupational Therapy in general and Orthopedic Cases."

The session concluded with a round-table discussion on the subject dealt with in the foregoing papers.

The following officers were re-elected; President, Mr. T. B. Kidner, New York, N. Y.; vice president, Dr. G. Canby Robinson, Vanderbilt Hospital, Nashville, Tenn.; secretary-treasurer, Mrs. Eleanor Clarke Slagle. The three retiring members of the board of managers were also re-elected: Dr. B. W. Carr, Washington, D. C.; Frederick W. Rockwell, Philadelphia, Pa., and Mrs. Frederick Dale Wood, Chicago, Ill.



Three views of American Occupational Therapy Association's exhibits showing the work of fifty-four hospitals.

## HOSPITAL DIETETIC COUNCIL HOLDS SECOND ANNUAL MEETING WITH A. H. A.

A PROGRAM filled with papers and discussions of significance to the profession rounded out the sessions of the second annual conference of the Hospital Dietetic Council held at Buffalo, N. Y., October 6-9. The conference opened Monday afternoon, October 6, with an invocation by the Rev. Cameron J. Davis, rector, Trinity Episcopal Church, Buffalo, an address of welcome by Dr. Charles Sumner Jones, dean, medical school, University of Buffalo, and the president's address, by Miss Rena S. Eckman, head dietitian, Michael Reese Hospital, Chicago, Ill.

"The Field of Nutrition—Its Radiations and Concentrations from Different Standpoints" was the subject treated by the various speakers of the opening program. The subject was discussed from the standpoint of the training center by Miss Mary E. Parker, Western University, Cleveland, Ohio. The following paragraphs summarize the leading thought of Miss Parker's paper.

"There has been recently a movement toward a greater differentiation of professions. With this development, the new profession finds itself in need of solidarity and new blood if it is to succeed in its struggle for recognition. It must, then, offer inducements which will attract people of ability. It must offer first, an income at least equal to that of other professions; second, an opportunity for development mentally; third, opportunity for contact with other professional people; fourth, opportunity for advancement; fifth, opportunity to develop initiative and to carry on a constructive program; and sixth, the promise of relief in time from the responsibilities of routine details.

### Chance to Do Real Construction Work

"The profession of hospital dietetics, as regards the above six points, does not compare advantageously. The salary is often small, compared to that offered in the teaching profession, and is coupled with long hours. The work of the student (and many times of the graduate) dietitian offers no chance for advanced study. Personal contact with superior people of professional training as found in college work is absent, the hospital contact being largely with help. Professional advancement and public recognition may be found in those hospitals in which the dietitians work with the doctor and the patients; where her work is entirely concerned with directing help this opportunity is lost. The hospital dietitian is very rarely free from detail. In one point only, then, does the hospital offer superior inducement—in the chance to show initiative and the ability to do real constructive work.

### Broad Field for Applied Dietetics

The subject was discussed from the "Wider Circle," by Miss Bertha M. Wood, Northfield Seminary, East Northfield, Mass.

In this circle, Miss Wood brought out, are included the following organizations, which use food as treatment, either preventive or curative: The out-patient department or dispensary; the district nurse association with its clinic centers and baby welfare stations; the public health centers through their dietitians trained in public health; child health organizations with their food experts; public schools in which dietitians are employed to help pupils in forming right food habits.

What the dietitian can contribute to the effectiveness of the medical man, was handled by Mr. Michael M. Davis, Jr., Committee on Dispensary Development, New York, N. Y., who emphasizes that in the out-patient department too much emphasis has been laid on equipment which is used in making diagnoses. The problem of getting results with ambulatory patients depends much more on treatment than on diagnoses. Such treatment is concerned largely with diet, occupation and hygiene, and in this connection the doctor is beginning to recognize that he needs a service which he alone cannot give—a service contributed by the dietitian in giving and establishing dietary plans. This applies not alone to the special diet diseases, but to general conditions as well. It applies also to all patients, whether in the hospital, clinic, office or home.

### Symposium on Menu Making

Monday evening's program was opened with an all dietitians' symposium on systems of menu making to avoid repetition, led by Miss Marian Peterson, Miami Valley Hospital, Dayton, Ohio and Miss Sara MacInnis, Colonial Hospital, Rochester, Minn.

Illustrative material was presented by Miss E. M. Geraghty, Lakeside Hospital, Cleveland, Ohio.

Miss Peterson brought out that doctors prefer plain food, steaks, chops, lettuce and tomato salads, pie and ice cream. Nurses demand as much variety as can be given. Greater satisfaction is obtained where meals are kept simple with emphasis on good preparation.

Miss MacInnis presented the following chart which has been useful in avoiding repetition in menus. The menus for two weeks may be put on one sheet.

Miss Geraghty brought out that as new dishes are tried out and accepted, the recipe may be classified for use for nurses, private patients, help, etc., and filed in the office on a card bearing the notation "Serve once a week" or "Serve once in two weeks," depending on the popularity of the dish. A duplicate of the recipe should be sent to the kitchen. If a menu check card is kept bearing the name of the dish, the frequency with which it is to be served and the dates upon which it has been served, it is easy to find when that dish may appear on the menu again.

### Selective Menus Successful

"The Selective Menu for Private Patients," was the subject handled by Miss Helen Clarke, Clifton Springs Sanitarium, Clifton Springs, N. Y., who stated that the plan of a selective menu for private patients is generally looked upon with approval where the organization of the hospital permits of its use. There are four ways of getting the menu to the patient: through the dietitian; through the head nurse; through the ward helper, and through the student nurse. After the menus have been marked by the patient, they are returned to the dietitian, who makes a summary of the orders. The menu with the patient's own marking is then placed on the tray and the order filled as requested.

Discussions were led by Miss Minna Roese, Leland Stanford Clinic, Stanford, Cal.; Miss Bertha M. Wood, Miss Irene Willson, Homeopathic Hospital, Pittsburgh, Pa.; Miss Margaret Fotheringham, Allegheny General Hos-

pital, Pittsburgh, Pa.; and Miss Margaret Gray.

Tuesday morning's session was taken up with papers on special dietary problems.

"Some New Advances in the Treatment of Diabetes" was the subject of a paper by Dr. John R. Williams, Highland Hospital, Rochester, N. Y.

"Since the introduction of insulin," said Dr. Williams, "the treatment of diabetes presents new aspects. The problem of nutrition remains the same; the method of treatment varies. (1) The patient may be kept on a low food level, a very strict diet, with a moderate under-nutrition, and insulin in only severe cases. Such patients must be well trained before their hospital discharge. (2) In other clinics, the patient is given a liberal diet with correspondingly large doses of insulin, and less emphasis on the training of the patient. (3) The diet may be very high in fat and restricted in protein, with insulin therapy for severe cases. (4) Hospitalization may be reserved for cases presenting surgical or other complications. In these clinics, attendance and instruction are more or less optional with the patient. (5) Many doctors give their patients printed diet lists, the diet depending on the degree of severity of the case. Insulin is administered one or more times weekly, usually without due consideration."

### The Caloric Kitchen in Rochester

"The Caloric Kitchen in Rochester—What it Has Taught About Food Habits" was the subject of the paper by Miss Mary A. Foley, Mayo Clinic, Rochester, Minn.

"To most people," said Miss Foley, "eating means satisfying desires and hunger with no thought of nutrition. To change this idea, the Rochester Calorie Kitchen was originated for the purpose of caring for ambulatory cases needing new food habits. The physician refers the case to the kitchen, where the dietitian interprets the doctor's diet order. The diet is made as much like the food at home as possible, with attention paid to personal likes and dislikes, financial, accu-

pational and racial conditions. Each patient is given individual instruction. After the patient is discharged, follow-up work is done through letters. In this way, good food habits are taught to entire families. Some of the conditions treated are constipation and obesity, in addition to metabolic disturbances. Fifty-five per cent of the meals served are anti-constipation meals. In obesity, both the quality and the quantity of the foods are observed."

Tuesday afternoon's program was the dietetic section of the American Hospital Association (See page 443).

Wednesday morning's session was devoted largely to problems of organization and management of dietary departments.

"The Organization of a Dietary Department" was the subject of a paper by Dr. Nathaniel W. Faxon, medical director, Strong Memorial Hospital, Rochester, N. Y.

Dr. Faxon outlined the contemplated plans for the dietary department of the Strong Memorial Hospital of the University of Rochester. This is a 200 bed hospital, connected with the City Hospital, also of 200 beds, and the kitchen of the Strong Memorial Hospital will feed both institutions. Plans are made for three types of service, feeding of patients, feeding of hospital personnel, and teaching of nurses.

### Contribution to Hospital Budget

"The Contribution of the Dietitian to the Control of the Food Budget," was the subject of a paper by Dr. Malcolm T. MacEachern, Associate director, American College of Surgeons, Chicago, Ill.

He showed that the dietitian is of importance to the hospital budget in several ways. (1) She can offer suggestions in the planning of the building which will mean a saving of time and energy. (2) She can plan equipment which will reduce the personnel. (3) The proper organization of an efficient dietary department makes for economy in both food and personnel. (4) She governs the quality of the food, whether she does the actual buying or works with the purchasing agent. (5) The amount of space to be devoted to storage and refrigeration is a matter to be settled when the building is planned, and should be decided with the aid of the dietitian. (6) She is directly responsible for the food service, the utilization of left overs and the amount of waste. (7) She provides a balanced diet for the entire hospital family. (8) She gives scientific special diets to patients with metabolic disturbances, thereby shortening their stay in the hospital. Where she also follows those diets into the home, she affects not only the food budget but the entire budget of the hospital.

"The dietitian has made it possible for the hospital to arrive at a more accurate cost accounting system," said Dr. MacEachern, "and the next problem should be the development of minimum standards for general hospitals."

"The Dietitian and Biochemical Research," was the subject presented by Roger Hubbard, Ph.D., Clifton Springs Sanitarium, Clifton Springs, N. Y.

Dr. Hubbard brought out that problems in biochemistry today are of two types, (1) those well controlled experiments done on animals, the results of which are applicable to man, and (2) clinical observations which cannot be so well controlled and must be verified by work on animals. The work of the dietitian comes under the latter type of experiment, in making the diet palatable and attractive to the patient. The biochemist, while he knows the needs of the patient in terms of



Miss Rena S. Eckman, head dietitian, Michael Reese Hospital, Chicago, Ill., president of the Hospital Dietetic Council.



Miss E. M. Geraghty, dietitian, Lakeside Hospital, Cleveland, Ohio.

protein, minerals, etc., could not satisfactorily translate such needs into actual foods.

Wednesday evening's session, which centered around the dietitian and the patient, was opened with a paper on "Protein Requirement in Health and Disease" by Dr. Phil L. Marsh, University Hospital, Ann Arbor, Mich.

"At times," said Dr. Marsh, "it is desirable to decrease protein intake. In the first place, overeating of protein may have some effect on the kidney. Dr. Newburgh has produced renal lesions in rabbits on high protein diets. And secondly, protein is an uneconomical food; physiologically, because it raises the metabolic rate; socially, because meat is an expensive food. These facts have raised the question of protein requirement in disease and in health."

#### Variety in the Weighed Diet

A paper on the "Variety and Palatability in the Weighed Diet," was read by Miss Mary M. Harrington, University Hospital, Ann Arbor, Mich., who dealt with the responsibility of the dietitian to the patient in teaching diet. She brought out that the dietitian must fill the physician's diet prescription, keeping in mind the standard of living of the patient. She must anticipate his home conditions and solve house problems before the patient is discharged. She must gain his confidence before he will cooperate. The diet should be a positive diet, that is, the patient should know what to eat rather than what not to eat. Instructions to men must include simple cookery directions. The dietitian has a responsibility in teaching good food habits to the entire family as well as to the individual patient. This work can be aided greatly by the public school teachers.

"The Serving of Therapeutic Food Preparations," was handled in a paper by Miss Eda S. Ferbert, Buffalo General Hospital, Buffalo, N. Y.

Foods on special diets must be served as ordered, she said. Some methods of accomplishing this end follow:

(1) The trays may be set up in the diet kitchen, sent to the ward on a dumb waiter, and carried directly to the patient. This method can be satisfactory only if the tray can be served immediately after it is set up.

(2) Special foods such as saltless vegetables, cream soups, low protein desserts, can be put up in quantities and sent to the ward in the morning. The diets are then served by the ward nurses. Under such a system, the weighed diets are served by the diet kitchen nurses.

(3) The food may be sent as under the second method, but sent three times daily. The weighed diets are then reheated by the floor nurse. In this method, the dietitian is apt not to have close enough contact with the diet.

(4) The special tray for each patient may be sent in a nest of casseroles, and the food reheated for serving by the ward nurse. Diabetic trays are served directly from the kitchen by the diet kitchen nurses. Weighed trays are returned to the diet kitchen for checking of unconsumed food.

#### Extension of Dietitian's Influence

"Extension of the Dietitian's Influence in the Home of the Dietetically Handicapped," was the subject of a paper read by Miss Dorothy M. Stewart, who told her audience that the dietitian has four standards by which she measures her instruction to her patient: (1) The diet must be reasonable to the patient, who must appreciate the relation of his special diet to a normal diet, or he will not follow it; (2) the instruction must be simple, because the

patient is not versed in percentage composition and food chemistry; (3) it must be interesting to hold the patient, whether it is given individually or to groups, and (4) the necessity for dieting must be made clear.

#### The Diet in Gastro-Intestinal Cases

Thursday morning's session opened with a paper on "The Dietetic Treatment of Gastro-Intestinal Condition," by Dr. John Alden Lichty, Clifton Springs Sanitarium, Clifton Springs, N. Y. The following are some of the ideas which Dr. Lichty left with his audience:

With broken bones, repair can be attained by complete rest. In diseases of the gastro-intestinal tract, absolute rest is impossible because the nutrition of the patient must be maintained. At best, there must be a compromise between nutrition and rest.

There are three types of gastro-intestinal disorders—acute, chronic and acute exacerbation of a chronic disease. The treatment for the first and third types is the same, rest by starvation for several days. The chronic case is the most difficult to treat, since the patient usually has lessened powers for repair due to continued under-nutrition.

#### Building Plans Discussed

"The Building Plans of the Dietary Department," were discussed by Mr. Edward F. Stevens, architect, Boston, Mass., who stated that every hospital should be planned so that all details are subservient to the patient. Since the serving of food is one of the greatest problems of the hospital, the planning of the kitchen is of utmost importance. The location of the kitchen must be decided upon when the plan is drawn, and upon it depends the location of the receiving room, the store room, and the size and shape of equipment.

"The Dietitian and Her Equipment," was the subject of a paper by Miss Vera W. Howard, consulting dietitian, Albert Pick & Co., Chicago, Ill., who stressed the idea that the selection of equipment for the kitchen should be made with a view to attaining satisfactory food service. Kitchen space should be generous and located in relation to other departments. Storage space should be ample to carry perishable supplies for three or four days. A list of equipment includes refrigerators, meat blocks and sink, vegetable peeler, tables and sinks, steam cookers, ranges, broilers, toasters, bake oven, bakers' and cooks' tables, mixing machines, ice cream freezer, dish-washing equipment, dish storage equipment, steam table and urn stand.

#### Food Injuries in Infants

Thursday morning's session was concluded with a paper on "Food Injuries," by Dr. Isaacs Abt, Michael Reese Hospital, Chicago, Ill., who stated that food injuries in infants may result from excess of food, from deficiency of food or from an incorrect mixture. Overfeeding seldom occurs at the breast. Underfeeding is much more prevalent. The injuries due to incorrect mixtures are classed as milk injuries, starch injuries and casein injuries.

"Modern Ideas in Infant Feeding" were discussed by Dr. De Witt H. Sherman, Buffalo, N. Y. In speaking of powdered milks, he said that in localities where it is difficult to get a supply of fresh milk, powdered milks have come into prominence. They are uncontaminated, and reasonably priced.

The conference was concluded with a business meeting for council members only, held Friday at ten A. M.

## MEETING OF HOSPITAL SOCIAL WORKERS CENTERS AROUND "RAISING STANDARDS"

THE semi-annual meeting of the American Association of Hospital Social Workers was held in Buffalo from October 6 to 10, 1924. The keynote of the entire program was expressed by the president of the association, Miss Mabel Wilson, director of social service, Children's Hospital, Boston, Mass., as "Raising Standards." Miss Wilson spoke of the necessity of working towards a higher standard of membership qualifications in the association, taking into consideration both training and achievement. The training committee is working on a plan whereby more and better trained hospital social workers may become available.

The committee on publications will make possible more inspiring literature—an enlarged bulletin, and a series of educational leaflets for general distribution to those interested in the organization and development of hospital social service. A very intensive study which is being undertaken by the committee on functions will ultimately be of great value in establishing standards of hospital social work, and will aid and safeguard the organization of new departments. A well-planned exhibit as means of interpretation to allied organizations is the responsibility of the exhibit committee.

Miss Wilson emphasized the necessity for the loyal support of the entire organization in working towards sound growth, and the need for a progressive program carefully planned and not merely a superficial expansion of scattered efforts. She especially urged concerted action in all sections, and in all committees to bring about in every part of the work higher standards.

"The Social Worker at the Admission Desk" was discussed by Miss Edith Howland, Johns Hopkins Hospital, Baltimore, Md., who for a year and a half, has held the position of admitting officer, and before taking that position has had long experience as a hospital social worker. Miss Howland stressed two important points for consideration in the admitting office: (a) the importance of right first contact with patient; (b) the importance of right first impression of patient. Every admitting office has one purpose, namely, to admit patients. Certain points which must always be considered are:

- (a) Medical
  - (1) What is wrong with the patient? What is the nature of his diagnosis?
  - (2) Is it an urgent case? Should it take precedence over others on the waiting list?
  - (3) Is he a suitable case for admission?
- (b) Social
  - (1) Will his support come from public or private funds?
  - (2) What rate can he pay—full or part?
  - (3) If not eligible, or no vacancy, what disposition should be made of him?

She discussed in detail the classes of patients dealt with, the sources from which they appear, and the varied problems they present. In considering the rate of pay for the patient an interview is held with the patient, or some responsible relative or friend, with a view to find-

ing out what type of patient or family is being dealt with; what grade of society is represented; what the income is from all sources; how many people must live on that income; what debts or special demands, like payment to a building association, are a drag upon the resources; what contributions are made to other dependents, where aid can be counted on from sick benefits, lodges, unions.

Sometimes, all this must be obtained within the hospital walls, or from the patient, or whoever officially represents him. Sometimes the interview is supplemented by the facts obtained by the social service department, from outside social agencies, or sources of information referred to by the patient, when his history is taken; employers, lodges, etc. The whole story is considered and balanced against the worker's own knowledge of trades and their rate of payment, proper allowances for food, housing, fuel, and standards of living, and the rate is based upon the conclusions.

It is the business of the admitting officer to establish the rate, and the business of the cashier's office to collect. It is the function of the admitting office to handle the case up to the point it becomes an accounting problem only. Cases demanding detailed investigations other than merely financial, are referred at once to the social service department, which in turn works with both the cashier and the admitting office. Efforts are made to forestall difficulties on admission by referring to social service at once anything that suggests complications so that when the time for discharge arrives a plan is usually worked out.

The social worker is peculiarly fitted for this admitting work. Her training is supposed to give her a fundamental understanding of life as it must be lived by the great mass of humanity, a knowledge of the causes of the many failures, and of the philosophy underlying the efforts of society to right itself. Her experience has made her familiar with concrete facts concerning social conditions, and actual costs of living, and the effects of unemployment.

### Employs Method of Case Worker

Her method of work is the case method. She considers the patient as a whole; she has a habit of complete analysis of the situation into its elements, and usually sickness is only one of the many problems. The habit of attack of the case worker is very similar to that of medical and legal case work; the social worker is trained to cast off false scents, but to stick to the real one to the bitter end. She has a habit of putting the job through, and following up her case until the problem is solved, or declared unsolvable. Loose ends are in abhorrence to a good social worker.

The functions of the admitting officer and of the social service worker are quite distinct, whether or not they



Miss Ida M. Cannon, director, social service department, Massachusetts General Hospital, Boston, (left), and Mrs. John Stowe, formerly of the social service department of the same hospital.

belong to the same department, as far as social service work is concerned. The former may discover a case and point out the problem and refer it to the social service department but it is the social service worker who takes up the problem for solution. It becomes a social service case, and the social service worker is responsible to the admitting officer only on such points as may touch upon the activities of that office. This difference in function should not interfere with any feeling of complete co-operation and of common responsibility.

Miss Howland stated that the admitting office offers a distinct field for social workers; the field is varied, broad, and decidedly interesting. The same problems arise, as in regular social service work, but they are handled from a different angle, and the method of approach is different. There is the same opportunity to unearth the problem, and a need for rapid analysis and a quick visualizing of the case. A thoroughly skilled social worker is needed.

In opening the discussion, Dr. Winford H. Smith, director, Johns Hopkins Hospital, Baltimore, Md., outlined the reasons which led him to the appointment of a social worker at the admission desk. He stated that three of the hospital's most important contacts with the public are (1) the admitting office; (2) the information desk; (3) the telephone service.

The principal requirements for an admitting officer are executive ability, an understanding of people and of economic and social conditions; tact, some medical knowledge, and the ability to know when to be insistent and when to yield. The admitting office is a business office, and the person in charge is a part of the administrative staff. This department should not be subordinated to the social service department—each has its own job, closely related, and working in harmony. This office is not a collecting department, but works very closely with the department responsible for collections through an exchange of information. Dr. Smith believes that a well-trained hospital social worker is better qualified than the average run of other types of workers for this particular office, and that it offers to the social worker an opportunity for some very real constructive work.

Miss Janet Geister, research worker of the Associated Out-Patient Clinics of New York City, spoke on "The Physician and the Medical Social Worker." She quoted the statement of the sub-committee of the medical section of the Associated Out-Patient Clinics, as follows:

"The physician whose problem is to restore his patient to health, effectiveness and earning power, may be confronted with certain symptoms that are insufficient evidence for a diagnosis, and may need for early consideration the facts concerning the patient's personal and family health history, health habits, and environments, or he may need to know the factors that influence an unsatisfactory response to treatment, or he may see the need of certain social adjustments before treatment can be insti-

tuted, and that it is for the purpose of rendering all these services that medical social work is organized, as indicating the increasing appreciation of the value of social service in the treatment and prevention of disease."

The responsibility for the selection of cases and the general management of the case should be placed on the physician; he is the one to diagnose the disease and to prescribe treatment. He is the head of the unit organized for the benefit of the patient and the social worker is a part of this unit. The actual selection of cases for social service depends on the policy of the institution, the types of clinics held, and the attitude of the clinic physicians; the daily intake of patients and the available number of social workers. The true basis for the selection of cases is the consideration from the social and economic aspects in their relation to the medical facts. The social worker is responsible to the doctor for the conduct of the case; to the social service supervisor for her actual technic.

Round-table discussions on the "Training for Psychiatric Social Work," and "Social Ethics," were held. The discussion on training for psychiatric social work

emphasized the need for careful consideration of the personality qualifications of students entering this field; that the instructor's responsibility in developing personality should be decided by consideration of the individual case—the ability of the individual student to overcome his or her difficulties along these lines. It was agreed that before professional training in psychiatric social work should be considered, the students must have had a university education with elementary and some advanced work in sociology, psychology, and in certain branches of science. A knowledge of community problems, criminal sociol-

ogy, public health, and some study of botany, zoology and heredity are considered very important and a valuable background.

The round table on the subject of ethics centered about two cases of deportation. These questions arose:

When the interest of the individual and that of society seem to conflict, to which is the primary responsibility of the social worker?

Can the two be reconciled by case work?

What is the ethical basis of our immigration law?

Have we an international as well as a national interest in view, in restricting immigration?

Is it ever right to break a law?

What is our responsibility in the use of our experience to correct bad laws?

Is there any difference between evading the immigration law and bootlegging?

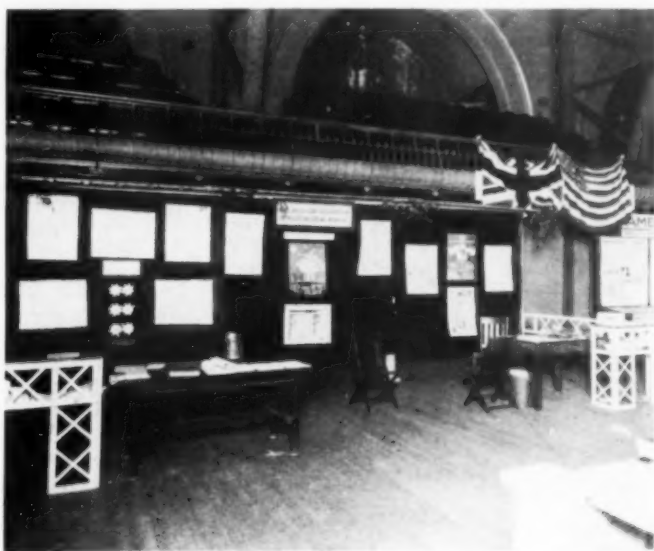
Is legal evasion of the law ever right?

When social agencies disagree as to the conduct of a case what are the rights and duties of each, that is, in regard to deporting?

What is the duty of the social worker in regard to criminal law breakers who are her clients?

In regard to persons against whom civil suit is being brought, the question of privileged communication was touched upon only briefly.

Fear is an instructor of great sagacity and the herald of all revolutions.—Emerson.



A view of the exhibit of the American Association of Hospital Social Workers.

# AMERICAN COLLEGE OF SURGEONS ANNOUNCES APPROVED LIST OF HOSPITALS FOR 1924

THE American College of Surgeons has completed the seventh annual survey of hospitals in the United States and Canada. The list of approved hospitals published herewith shows the result of: (1) the seventh survey of hospitals of one hundred beds and over; (2) the third survey of hospitals of fifty to one hundred beds; (3) the preliminary survey of (a) hospitals of thirty-five to fifty beds, (b) National Homes for Disabled Volunteer Soldiers, (c) Marine Hospitals of the United States Public Health Service.

During the year twenty-one hospitals in New Zealand,

Australia, and Hawaii were visited, but as the survey has not yet been finished the list as published in this report is incomplete. It is expected that the survey of these hospitals will be completed before the first of the year, and the list of hospitals published in the January *Bulletin of the American College of Surgeons*.

Following is a list of approved hospitals for 1924 up to October 1. The asterisk indicates that certain hospitals have accepted the requirements which result in the best scientific care of the patient but are not, for the lack of time or other reasons, carrying them out in every detail:

## UNITED STATES

### ALABAMA

- 100 or more beds  
Birmingham Baptist Hospital, Birmingham  
Employees' Hospital, T.C.I.R.R. Co., Birmingham  
Hilman Hospital, Birmingham  
Moody Hospital, Gotham  
Mobile City Hospital, Mobile  
Norwood Hospital, Birmingham  
Providence Infirmary, Mobile  
St. Vincent's Hospital, Birmingham  
South Highlands Infirmary, Birmingham  
50 to 100 beds  
\*Alabama Baptist Hospital, Selma  
Children's Hospital, Birmingham  
\*Frazier Hospital, Dothan  
John A. Andrew Memorial Hospital, Tuskegee  
Vaughan Memorial Hospital, Selma  
Walker County Hospital, Jasper  
35 to 50 beds  
\*Sylacauga Infirmary, Sylacauga

### ARIZONA

- 100 or more beds  
Arizona Deaconess Hospital, Phoenix  
St. Joseph's Hospital, Phoenix  
50 to 100 beds  
\*Arizona Hospital and Sanatorium, Tucson  
\*St. Mary's Hospital and Sanatorium, Tucson  
35 to 50 beds  
Miami Inspiration Hospital, Miami  
ARKANSAS  
100 or more beds  
Logan H. Roots City Memorial Hospital, Little Rock  
St. Bernard's Hospital, Jonesboro  
St. Louis Southwestern R. R. Hospital, Texarkana  
St. Vincent's Infirmary, Little Rock  
Sparks Memorial Hospital, Fort Smith  
50 to 100 beds  
Baptist Hospital, Little Rock  
Fayetteville City Hospital, Fayetteville  
Leo N. Levi Memorial Hospital, Hot Springs  
Michael Mesger Memorial Hospital, Texarkana  
\*St. John's Hospital, Fort Smith  
St. Luke's Hospital and Annex, Little Rock  
35 to 50 beds  
\*Helena Hospital, Helena

### CALIFORNIA

- 100 or more beds  
Alameda County Hospital, San Leandro  
\*Angelus Hospital Association, Los Angeles  
California Lutheran Hospital, Los Angeles  
Children's Hospital, Los Angeles  
Fabiola Hospital, Oakland  
\*Franklin Hospital, San Francisco  
French Hospital, San Francisco  
General Hospital, Fresno  
General Hospital, Santa Barbara  
\*Glendale Sanitarium and Hospital, Glendale  
Golden State Hospital, Los Angeles  
Hahnemann Hospital, San Francisco  
Hollywood Hospital, Hollywood  
Hospital for Children, San Francisco  
Hospital of the Good Samaritan, Los Angeles  
Kern General Hospital, Bakersfield  
Loma Linda Sanitarium and Hospital, Loma Linda  
Los Angeles General Hospital, Los Angeles  
Mary's Help Hospital, San Francisco  
Methodist Hospital, Los Angeles  
Mt. Zion Hospital, San Francisco  
O'Connor Sanitarium, San Jose  
\*Orange County Hospital, Orange  
Paradise Valley Hospital, National City  
Pasadena Hospital, Pasadena  
Providence Hospital, Oakland  
Sacramento Hospital, Sacramento  
\*St. Francis Hospital, San Francisco  
\*St. Francis Hospital, Santa Barbara

- St. Helen's Sanitarium, Sanitarium  
St. Joseph's Hospital, San Diego  
St. Joseph's Hospital, San Francisco  
St. Luke's Hospital, San Francisco  
St. Mary's Hospital, San Francisco  
St. Vincent's Hospital, Los Angeles  
Samuel Merritt Hospital, Oakland  
San Bernardino County Hospital, San Bernardino  
San Diego County Hospital, San Diego  
San Francisco Hospital, San Francisco  
San Joaquin General Hospital, French Camp  
Santa Barbara Cottage Hospital, Santa Barbara  
Santa Clara County Hospital, San Jose  
Santa Fe Coast Lines Hospital, Los Angeles  
Seaside Hospital, Long Beach  
Southern Pacific Hospital, San Francisco  
Stanford University and Lane Hospitals, San Francisco  
University of California Hospital, San Francisco  
White Memorial Hospital, Los Angeles  
50 to 100 beds  
Clara Barton Hospital, Los Angeles  
Community Hospital, San Mateo  
Kaspere Cohn Hospital, Los Angeles  
Mercy Hospital, Bakersfield  
\*Mills Memorial Hospital, San Mateo  
Murphy Memorial Hospital, Whittier  
Orthopedic Hospital, Los Angeles  
Ramona and Sequoia Hospitals, San Bernardino  
Shriners' Orthopedic Hospital, San Francisco  
St. Mary's Long Beach Hospital, Long Beach  
Woodland Sanitarium, Woodland  
35 to 50 beds  
Baby's Hospital, Oakland  
\*Palo Alto Hospital, Palo Alto

### COLORADO

- 100 or more beds  
Beth-El Hospital, Colorado Springs  
Boulder-Colorado Sanitarium, Boulder  
Children's Hospital, Denver  
Denver General Hospital, Denver  
Glockner General Hospital, Colorado Springs  
Mercy Hospital, Denver  
Minnequa Hospital, Pueblo  
St. Anthony's Hospital, Denver  
St. Francis Hospital, Colorado Springs  
St. Joseph's Hospital, Denver  
St. Luke's Hospital, Denver  
St. Mary's Hospital, Pueblo  
50 to 100 beds  
Beth Israel Hospital, Denver  
Community Hospital, Boulder  
Denver and Rio Grande Western R. R. Hospital, Salida  
\*Red Cross Hospital, Salida  
35 to 50 beds  
Atchison, Topeka and Santa Fe R. R. Hospital, La Junta  
Parkview Hospital, Pueblo

### CONNECTICUT

- 100 or more beds  
Bridgeport Hospital, Bridgeport  
Danbury Hospital, Danbury  
Grace Hospital, New Haven  
Greenwich Hospital, Greenwich  
Hartford Hospital, Hartford  
Hospital of St. Raphael, New Haven  
Lawrence and Memorial Associated Hospitals, New London  
Meriden Hospital, Meriden  
Middlesex Hospital, Middletown  
New Britain Hospital, New Britain  
New Haven Hospital, New Haven  
St. Francis Hospital, Hartford  
St. Mary's Hospital, Waterbury  
St. Vincent's Hospital, Bridgeport  
Stamford Hospital, Stamford  
Waterbury Hospital, Waterbury

### 50 to 100 beds

- \*Charlotte Hungerford Hospital, Torrington  
Manchester Memorial Hospital, South Manchester  
Mt. Sinai Hospital, Hartford  
\*Municipal Hospital, Hartford

### DELAWARE

- 100 or more beds  
Delaware Hospital, Wilmington  
50 to 100 beds  
Homeopathic Hospital, Wilmington  
DISTRICT OF COLUMBIA

- 100 or more beds  
Central Dispensary and Emergency Hospital, Washington  
Children's Hospital, Washington  
Columbia Hospital for Women, Washington  
Freedman's Hospital, Washington  
\*Gallinger Municipal Hospital, Washington  
Garfield Memorial Hospital, Washington  
George Washington University Hospital, Washington  
Georgetown University Hospital, Washington  
Providence Hospital, Washington  
Washington Sanitarium, Washington

### FLORIDA

- 100 or more beds  
Duval County Hospital, Jacksonville  
Miami City Hospital, Miami  
St. Luke's Hospital, Jacksonville  
50 to 100 beds  
\*East Coast Hospital, St. Augustine  
Faith Hospital, St. Petersburg  
Gordon Keller Memorial Hospital, Tampa  
35 to 50 beds  
Bayside Hospital, Tampa  
Riverside Hospital, Jacksonville

### GEORGIA

- 100 or more beds  
Davis-Fischer Hospital, Atlanta  
Georgia Baptist Hospital, Atlanta  
Grady Memorial Hospital, Atlanta  
Harbin Hospital, Rome  
Piedmont Sanitarium, Atlanta  
\*Rawlings Sanitarium, Sandersville  
St. Joseph's Infirmary, Atlanta  
University Hospital, Augusta  
Wesley Memorial Hospital, Atlanta  
50 to 100 beds  
Athens General Hospital, Athens  
Atlantic Coast Lines Hospital, Waycross  
Downey Hospital, Gainesville  
\*Dunson Hospital, LaGrange  
Scottish Rite Hospital, Decatur  
Thomasville City Hospital, Thomasville  
\*Wilhenford Hospital, Augusta  
Wise Sanitarium, Plains

### IDAHO

- 100 or more beds  
St. Alphonsus Hospital, Boise  
50 to 100 beds  
Latter-Day Saints Hospital, Idaho Falls  
Pocatello General Hospital, Pocatello  
Providence Hospital, Wallace  
St. Anthony's Hospital, Pocatello  
St. Joseph's Hospital, Lewiston  
St. Luke's Hospital, Boise

### ILLINOIS

- 100 or more beds  
Augustana Hospital, Chicago  
Chicago Lying-in Hospital, Chicago  
Chicago Memorial Hospital, Chicago  
Children's Memorial Hospital, Chicago  
Columbus Hospital, Chicago  
Cook County Hospital, Chicago  
\*Emergency Hospital, Kankakee  
Evanston Hospital, Evanston  
Frances E. Willard Hospital, Chicago  
Garfield Park Hospital, Chicago

(Continued on bottom of next page.)

## NUMBER OF HOSPITALS MEETING THE MINIMUM STANDARD

	100 or more beds			50 to 100 beds			All hospitals over 50 beds		
	Number of hospitals	Approved		Number of hospitals	Approved		Number of hospitals	Approved	
		Number	Percentage		Number	Percentage		Number	Percentage
Alabama.....	10	9	90	17	6	35.3	27	15	55.6
Arizona.....	2	2	100	5	2	40	7	4	57.1
Arkansas.....	6	5	83.3	10	6	60	16	11	68.8
California.....	56	48	85.7	34	11	32.4	90	50	65.6
Colorado.....	12	12	100	9	4	44.4	21	16	76.2
Connecticut.....	16	16	100	12	4	33.3	28	20	74.3
Delaware.....	1	1	100	2	1	50	3	2	66.7
District of Columbia.....	12	10	83.3	1	..	..	13	10	76.9
Florida.....	6	3	50	9	3	33.3	15	6	40
Georgia.....	12	9	75	17	8	47.1	29	17	58.6
Idaho.....	1	1	100	8	6	75	9	7	77.8
Illinois.....	69	47	66.7	61	20	34.4	130	67	51.5
Indiana.....	22	18	81.8	15	10	66.7	37	28	75.7
Iowa.....	14	13	92.9	24	15	62.5	38	28	73.7
Kansas.....	6	6	100	28	17	60.7	34	23	67.6
Kentucky.....	8	8	100	18	9	50	26	17	69.2
Louisiana.....	7	7	100	11	8	72.7	18	15	83.3
Maine.....	5	5	100	11	4	36.4	16	9	56.3
Maryland.....	16	15	93.8	10	7	70	26	22	84.6
Massachusetts.....	49	44	89.8	34	20	58.8	83	64	77.1
Michigan.....	26	24	92.3	22	14	63.6	48	38	79.2
Minnesota.....	27	26	96.3	21	11	52.4	48	37	77.1
Mississippi.....	6	4	66.7	10	3	30	16	7	43.7
Missouri.....	35	26	74.3	19	10	52.6	54	36	66.7
Montana.....	9	7	77.8	9	5	55.6	18	12	66.7
Nebraska.....	12	8	66.7	13	4	30.8	25	12	48
Nevada.....	0	..	..	2	2	100	2	2	100
New Hampshire.....	2	1	50	12	10	83.3	14	11	78.6
New Jersey.....	38	36	94.7	13	10	76.9	51	46	90.2
New Mexico.....	0	..	..	5	4	80	5	4	80
New York.....	137	122	89	78	39	50	215	161	74.9
North Carolina.....	8	5	62.5	22	15	68.2	30	20	66.7
North Dakota.....	5	5	100	7	2	28.6	12	7	58.3
Ohio.....	44	42	95.5	37	24	64.9	81	66	81.5
Oklahoma.....	2	2	100	14	2	14.3	16	4	25
Oregon.....	5	5	100	14	4	28.6	19	9	47.4
Pennsylvania.....	89	79	88.7	82	38	46.3	171	117	68.4
Rhode Island.....	4	4	100	3	2	66.7	7	6	85.7
South Carolina.....	7	4	57.1	9	3	33.3	16	7	43.7
South Dakota.....	5	5	100	12	10	83.3	17	15	88.2
Tennessee.....	10	9	90	12	8	66.7	22	17	77.3
Texas.....	21	19	90.5	32	17	53.1	53	36	67.9
Utah.....	5	5	100	1	1	100	6	6	100
Vermont.....	1	1	100	5	4	80	6	5	83.3
Virginia.....	7	7	100	31	22	71	38	29	76.3
Washington.....	19	16	84.2	19	9	47.4	38	25	65.8
West Virginia.....	8	6	75	21	13	61.9	29	19	65.5
Wisconsin.....	27	22	81.5	26	11	42.3	53	33	62.3
Wyoming.....	2	..	..	6	3	50	8	3	37.5
Totals for United States.....	891	769	86.3	893	461	51.6	1784	1230	68.9
Alberta.....	7	7	100	4	4	100	11	11	100
British Columbia.....	7	7	100	7	3	42.9	14	10	71.4
Manitoba.....	9	9	100	1	..	..	10	9	90
New Brunswick.....	2	2	100	9	8	88.9	11	10	91
Nova Scotia.....	3	3	100	9	9	100	12	12	100
Ontario.....	26	20	76.9	30	11	36.7	56	31	55.4
P. E. I.....	0	..	..	3	3	100	3	3	100
Quebec.....	11	10	91	9	5	55.6	19	15	78.9
Saskatchewan.....	5	4	80	8	4	50	13	8	61.5
Totals for Canada.....	70	62	88.6	80	47	58.8	149	109	72.6
Grand Totals.....	961	831	86.5	973	508	52.2	1933	1339	69.3

Grant Hospital, Chicago  
 \*Hinsdale Sanitarium, Hinsdale  
 Hospital of St. Anthony de Padua, Chicago  
 Illinois Central Hospital, Chicago  
 Illinois Eye and Ear Infirmary, Chicago  
 John B. Murphy Hospital, Chicago  
 Lake View Hospital, Danville

Lutheran Deaconess Hospital, Chicago  
 Lutheran Memorial Hospital, Chicago  
 Mercy Hospital, Chicago  
 Michael Reese Hospital, Chicago  
 Misericordia Hospital, Chicago  
 Mt. Sinai Hospital, Chicago  
 Oak Park Hospital, Oak Park

Presbyterian Hospital, Chicago  
 Ravenswood Hospital, Chicago  
 Rockford Hospital, Rockford  
 St. Anne's Hospital, Chicago  
 St. Anthony's Hospital, Rock Island  
 St. Bernard's Hospital, Chicago  
 St. Elizabeth's Hospital, Chicago

\*St. Elizabeth's Hospital, Danville  
 St. Francis Hospital, Blue Island  
 St. Francis Hospital, Evanston  
 St. Francis Hospital, Peoria  
 St. Joseph's Hospital, Chicago  
 St. Joseph's Hospital, Joliet  
 St. Luke's Hospital, Chicago  
 \*St. Mary's Hospital, Cairo  
 St. Mary's Hospital, East St. Louis  
 St. Mary's Hospital, Quincy  
 St. Mary of Nazareth Hospital, Chicago  
 \*Silver Cross Hospital, Joliet  
 South Shore Hospital, Chicago  
 Swedish Covenant Hospital, Chicago  
 University Hospital, Chicago  
 Wesley Memorial Hospital, Chicago

50 to 100 beds  
 Blessing Hospital, Quincy  
 Highland Park Hospital, Highland Park  
 Huber Memorial Hospital, Pana  
 Illinois Masonic Hospital, Chicago  
 Ingalls Memorial Hospital, Harvey  
 Kewanee Public Hospital, Kewanee  
 Lake View Hospital, Chicago  
 \*Lutheran Hospital, Moline  
 \*Moline Public Hospital, Moline  
 North Chicago Hospital, Chicago  
 Olney Sanitarium, Olney  
 Our Savior's Hospital, Jacksonville  
 \*Passavant Memorial Hospital, Chicago  
 Passavant Memorial Hospital, Jacksonville  
 \*Post-Graduate Hospital, Chicago  
 \*Provident Hospital, Chicago  
 St. Andrew's Hospital, Murphysboro  
 \*St. Francis Hospital, Freeport  
 \*St. Francis Hospital, Kewanee  
 Washington Boulevard Hospital, Chicago

35 to 50 beds  
 Streeter Hospital, Chicago  
 INDIANA  
 100 or more beds  
 Fort Wayne Lutheran Hospital, Fort Wayne  
 Gary Hospital, Gary  
 Indianapolis City Hospital, Indianapolis  
 \*Methodist Episcopal Hospital, Indianapolis  
 \*Methodist Hospital, Gary  
 Protestant Deaconess Hospital, Evansville  
 Robert W. Long Hospital, Indianapolis  
 St. Anthony's Hospital, Terre Haute  
 St. Edward's Hospital, New Albany  
 St. Elizabeth's Hospital, LaFayette  
 St. Joseph's Hospital, Ft. Wayne  
 \*St. Joseph's Hospital, Mishawaka  
 St. Joseph's Hospital, South Bend  
 St. Margaret's Hospital, Hammond  
 St. Mary's Hospital, Evansville  
 St. Mary's Mercy Hospital, Gary  
 \*St. Vincent's Hospital, Indianapolis  
 Union Hospital, Terre Haute

50 to 100 beds  
 Epworth Hospital, South Bend  
 Grant County Hospital, Marion  
 Holy Family Hospital, LaPorte  
 LaFayette Home Hospital, LaFayette  
 Muncie Home Hospital, Muncie  
 Reid Memorial Hospital, Richmond  
 St. John's Hospital, Anderson  
 \*St. Joseph's Hospital, Logansport  
 \*Wabash Valley Sanitarium and Hospital, LaFayette  
 Walker Hospital, Evansville

35 to 50 beds  
 \*Hayden Hospital, Evansville  
 IOWA  
 100 or more beds  
 Finley Hospital, Dubuque  
 Iowa Lutheran Hospital, Des Moines  
 Iowa Methodist Hospital, Des Moines  
 Jennie Edmundson Hospital, Council Bluffs  
 Mercy Hospital, Cedar Rapids  
 Mercy Hospital, Council Bluffs  
 Mercy Hospital, Davenport  
 \*Mercy Hospital, Des Moines  
 Mercy Hospital, Iowa City  
 St. Joseph's Hospital, Dubuque  
 St. Joseph's Mercy Hospital, Sioux City  
 St. Vincent's Hospital, Sioux City  
 University Hospital, Iowa City

50 to 100 beds  
 Des Moines City Hospital, Des Moines  
 Iowa Congregational Hospital, Des Moines  
 Iowa State College Hospital, Ames  
 \*Jane Lamb Memorial Hospital, Clinton  
 \*Lutheran Hospital, Sioux City  
 \*Methodist Hospital, Sioux City  
 \*Ottumwa Hospital, Ottumwa  
 Park Hospital, Mason City  
 St. Francis Hospital, Waterloo  
 St. Joseph's Hospital, Keokuk  
 St. Joseph's Mercy Hospital, Clinton  
 St. Joseph's Mercy Hospital, Ft. Dodge  
 St. Joseph's Mercy Hospital, Mason City  
 St. Joseph's Mercy Hospital, Waverly  
 St. Luke's Hospital, Cedar Rapids

35 to 50 beds  
 \*Davenport Hospital, Davenport  
 KANSAS  
 100 or more beds  
 Bethany Methodist Hospital, Kansas City  
 St. Francis Hospital, Wichita  
 St. Margaret's Hospital, Kansas City  
 Santa Fe Hospital, Topeka  
 Wesley Hospital, Wichita  
 \*Wichita Hospital, Wichita

50 to 100 beds  
 Axtell Hospital, Newton  
 Bell Memorial Hospital, Kansas City  
 Bethel Deaconess Hospital, Newton  
 Christ Hospital, Topeka  
 Grace Hospital, Hutchinson  
 Halstead Hospital, Halstead  
 \*Missouri, Kansas, and Texas R.R. Hospital, Parsons  
 Mount Carmel Hospital, Pittsburg  
 Providence Hospital, Kansas City  
 St. Anthony's Hospital, Hays  
 St. Anthony's Murdock Memorial Hospital, Sabetha  
 St. Elizabeth's Hospital, Hutchinson  
 St. Francis Hospital, Topeka  
 St. John's Hospital, Salina  
 St. Joseph's Hospital, Concordia  
 \*St. Mary's Hospital, Winfield  
 St. Rose's Hospital, Great Bend

35 to 50 beds  
 St. Luke's Hospital, El Dorado  
 KENTUCKY  
 100 or more beds  
 Good Samaritan Hospital, Lexington  
 Louisville City Hospital, Louisville  
 Norton Memorial Hospital, Louisville  
 St. Anthony's Hospital, Louisville  
 St. Elizabeth's Hospital, Covington  
 St. Joseph's Hospital, Lexington  
 St. Joseph's Infirmary, Louisville  
 Sts. Elizabeth and Mary Hospital, Louisville

50 to 100 beds  
 \*Ashland General Hospital, Ashland  
 \*Booth Memorial Hospital, Covington  
 \*Children's Free Hospital, Louisville  
 \*Jewish Hospital, Louisville  
 Illinois Central Hospital, Paducah  
 \*King's Daughters Hospital, Ashland  
 Methodist Episcopal Hospital, Louisville  
 Speers Memorial Hospital, Dayton  
 Wm. Mason Memorial Hospital, Murray

35 to 50 beds  
 Robinson Hospital, Berea  
 LOUISIANA  
 100 or more beds  
 Charity Hospital, New Orleans  
 \*Charity Hospital, Shreveport  
 Hotel Dieu, New Orleans  
 \*Presbyterian Hospital, New Orleans  
 St. Francis Sanitarium, Monroe  
 T. E. Schumpert Memorial Hospital, Shreveport  
 Touro Infirmary, New Orleans  
 50 to 100 beds  
 \*Baptist Hospital, Alexandria  
 Eye, Ear, Nose, and Throat Hospital, New Orleans  
 Flint-Goodridge Hospital, New Orleans  
 Highland Sanitarium, Shreveport  
 Illinois Central R. R. Hospital, New Orleans  
 North Louisiana Sanitarium, Shreveport  
 St. Patrick's Sanitarium, Lake Charles  
 Shriner's Hospital for Crippled Children, Shreveport

35 to 50 beds  
 \*New Orleans Dispensary for Women and Children, New Orleans

MAINE  
 100 or more beds  
 Central Maine General Hospital, Lewiston  
 Eastern Maine General Hospital, Bangor  
 \*Maine Eye and Ear Infirmary, Portland  
 Maine General Hospital, Portland  
 St. Mary's General Hospital, Lewiston

50 to 100 beds  
 Bath City Hospital, Bath  
 Children's Hospital, Portland  
 \*St. Barnabas Hospital, Portland  
 \*State Street Hospital, Portland

MARYLAND  
 100 or more beds  
 Allegany Hospital, Cumberland  
 Bay View City Hospital, Baltimore  
 Church Home and Infirmary, Baltimore  
 Colonial Hospital, Baltimore  
 \*Franklin Square Hospital, Baltimore  
 Hebrew Hospital and Asylum, Baltimore  
 Hospital for Women of Maryland, Baltimore  
 Johns Hopkins Hospital, Baltimore  
 Maryland General Hospital, Baltimore  
 Mercy Hospital, Baltimore  
 \*Peninsula General Hospital, Salisbury  
 St. Agnes Hospital, Baltimore  
 St. Joseph's Hospital, Baltimore  
 Union Memorial Hospital, Baltimore  
 University Hospital, Baltimore

50 to 100 beds  
 \*Cambridge-Maryland Hospital, Cambridge  
 Children's Hospital School, Baltimore  
 Emergency Hospital, Easton  
 Frederick City Hospital, Frederick  
 \*James Lawrence Kerman Hospital, Baltimore  
 South Baltimore Hospital, Baltimore  
 Western Maryland Hospital, Cumberland

35 to 50 beds  
 Howard A. Kelley Hospital, Baltimore  
 Volunteers of America Hospital, Baltimore

MASSACHUSETTS  
 100 or more beds  
 Beverly Hospital, Beverly  
 Boston City Hospital, Boston  
 Boston Lying-in Hospital, Boston  
 Brockton Hospital, Brockton

Burbank Hospital, Fitchburg  
 Cambridge City Hospital, Cambridge  
 Cambridge Hospital, Cambridge  
 Carney Hospital, Boston  
 Children's Hospital, Boston  
 City Hospital, Fall River  
 Cooley-Dickinson Hospital, Northampton  
 Free Hospital for Women, Boston  
 Gale Hospital, Haverhill  
 Henry Heywood Memorial Hospital, Gardner  
 Holyoke City Hospital, Holyoke  
 House of Mercy Hospital, Pittsfield  
 Lawrence General Hospital, Lawrence  
 Long Island Hospital, Boston  
 Lowell Corporation Hospital, Lowell  
 Lowell General Hospital, Lowell  
 Lynn Hospital, Lynn  
 Malden Hospital, Malden  
 Massachusetts Charitable Eye and Ear Hospital, Boston  
 Massachusetts General Hospital, Boston  
 Massachusetts Homeopathic Hospital, Boston  
 Memorial Hospital, Worcester  
 Mercy Hospital, Springfield  
 New England Deaconess Hospital, Boston  
 New England Hospital for Women and Children, Boston  
 Newton Hospital, Newton Lower Falls  
 Noble Hospital, Westfield  
 Peter Bent Brigham Hospital, Boston  
 Providence Hospital, Holyoke  
 Robert Breck Brigham Hospital, Boston  
 St. Elizabeth's Hospital, Boston  
 St. John's Hospital, Lowell  
 St. Luke's Hospital, Bedford  
 St. Vincent's Hospital, Worcester  
 Salem Hospital, Salem  
 Springfield Hospital, Springfield  
 Truesdale Hospital, Fall River  
 Union Hospital, Fall River  
 Waltham Hospital, Waltham  
 Worcester City Hospital, Worcester

50 to 100 beds  
 Anna Jaques Hospital, Newburyport  
 Beth Israel Hospital, Boston  
 Charles Choate Memorial Hospital, Woburn  
 \*Chelsea Memorial Hospital, Chelsea  
 \*City Hospital, Quincy  
 Clinton Hospital, Clinton  
 \*Emerson Hospital, Boston  
 Farren Memorial Hospital, Montague City  
 Faulkner Hospital, Boston  
 Goddard Hospital, Brockton  
 \*Hale Hospital, Haverhill  
 \*Hart Private Hospital, Roxbury  
 House of the Good Samaritan, Boston  
 Infants' Hospital, Boston  
 \*Josiah B. Thomas Hospital, Peabody  
 Melrose Hospital, Melrose  
 North Adams Hospital, North Adams  
 Somerville Hospital, Somerville  
 \*Sturdy Memorial Hospital, Attleboro  
 \*Symmes Arlington Hospital, Arlington

35 to 50 beds  
 New England Deaconess Hospital, Boston

MICHIGAN  
 100 or more beds  
 Battle Creek Sanitarium, Battle Creek  
 Blodgett Memorial Hospital, Grand Rapids  
 Butterworth Hospital, Grand Rapids  
 Children's Free Hospital, Detroit  
 Detroit Receiving Hospital, Detroit  
 Evangelical Deaconess Hospital, Detroit  
 Grace Hospital, Detroit  
 Edward W. Sparrow Hospital, Lansing  
 Harper Hospital, Detroit  
 Hackley Hospital, Muskegon  
 Henry Ford Hospital, Detroit  
 Highland Park General Hospital, Highland Park  
 House of Providence, Detroit  
 Hurley Hospital, Flint  
 Mercy Hospital, Muskegon  
 New Borgess Hospital, Kalamazoo  
 Old Borgess Hospital, Kalamazoo  
 St. Joseph's Hospital, Ann Arbor  
 St. Mary's Hospital, Grand Rapids  
 St. Mary's Hospital, Detroit  
 Saginaw General Hospital, Saginaw  
 University Hospital, Ann Arbor  
 W. A. Foot Memorial Hospital, Jackson  
 Women's Hospital and Infants' Home, Detroit

50 to 100 beds  
 Bronson Hospital, Kalamazoo  
 Delray Industrial Hospital, Detroit  
 Detroit Eye and Ear Hospital, Detroit  
 Jefferson Clinic Hospital, Detroit  
 Memorial Hospital, Owosso  
 \*Mercy Hospital, Cadillac  
 Mercy Hospital, Jackson  
 \*St. Francis Hospital, Escanaba  
 St. Joseph's Hospital, Hancock  
 St. Joseph's Hospital, Detroit  
 St. Joseph's Hospital, Mt. Clemens  
 \*St. Mary's Hospital, Marquette  
 St. Mary's Hospital, Saginaw  
 Woman's Hospital, Saginaw

35 to 50 beds  
 Ishpeming Hospital, Ishpeming  
 MINNESOTA  
 100 or more beds  
 Abbott Hospital, Minneapolis  
 Ancker Memorial Hospital, St. Paul

Asbury Hospital, Minneapolis  
Bethesda Hospital, St. Paul  
Charles T. Miller Hospital, St. Paul  
Colonial Hospital, Rochester  
Deaconess Hospital, Minneapolis  
Eitel Hospital, Minneapolis  
Fairview Hospital, Minneapolis  
Kahler Hospital, Rochester  
Minneapolis General Hospital, Minneapolis  
Minnesota State Hospital for Indigent Children, St. Paul  
Mounds Park Sanitarium, St. Paul  
Northern Pacific Beneficial Association Hospital, St. Paul  
\*Northwestern Hospital, Minneapolis  
St. Barnabas Hospital, Minneapolis  
St. Joseph's Hospital, St. Paul  
St. Luke's Hospital, Duluth  
St. Luke's Hospital, St. Paul  
St. Mary's Hospital, Duluth  
St. Mary's Hospital, Minneapolis  
St. Mary's Hospital, Rochester  
St. Paul Hospital, St. Paul  
Swedish Hospital, Minneapolis  
University of Minnesota Hospital, Minneapolis  
Worrell Hospital, Rochester

50 to 100 beds  
Hill Crest Surgical Hospital, Minneapolis  
\*Immanuel Hospital, Mankato  
\*St. Gabriel's Hospital, Little Falls  
St. John's Hospital, St. Paul  
St. Joseph's Hospital, Brainerd  
St. Joseph's Hospital, Mankato  
St. Luke's Hospital, Fergus Falls  
St. Raphael's Hospital, St. Cloud  
Shriners' Hospital for Crippled Children, Minneapolis  
Warren General Hospital, Warren  
Winona General Hospital, Winona

35 to 50 beds  
Morgan Park Hospital, Duluth  
MISSISSIPPI  
100 or more beds  
Kings Daughters Hospital, Gulfport  
Matty Hersee Hospital, Meridian  
Mississippi State Charity Hospital, Jackson  
South Mississippi Charity Hospital, Laurel

50 to 100 beds  
Jackson Infirmary, Jackson  
Mississippi Baptist Hospital, Jackson  
Vicksburg Infirmary, Vicksburg  
35 to 50 beds  
Dr. Hairston's Hospital, Meridian  
J. Z. George Memorial Hospital, A and M. College  
Houston Hospital, Houston  
South Mississippi General Hospital, Hattiesburg  
Winona Infirmary, Winona

MISSOURI  
100 or more beds  
Alexian Brothers Hospital, St. Louis  
Barnes Hospital, St. Louis  
Bethesda Hospital, St. Louis  
Children's Hospital, Kansas City  
Christian Church Hospital, Kansas City  
\*Evangelical Deaconess Home and Hospital, St. Louis  
Grace Hospital, Kansas City  
Frisco Employees' Hospital, St. Louis  
Jewish Hospital, St. Louis  
Kansas City General Hospital, Kansas City  
Lutheran Hospital, St. Louis  
Missouri Baptist Sanitarium, St. Louis  
Missouri Pacific R. R. Hospital, St. Louis  
Old General Hospital, Kansas City  
Research Hospital, Kansas City  
St. Anthony's Hospital, St. Louis  
St. John's Hospital, St. Louis  
St. Joseph's Hospital, Kansas City  
St. Louis Children's Hospital, St. Louis  
St. Louis City Hospital, St. Louis  
St. Louis City Hospital, No. 2, St. Louis  
St. Louis Mullanphy Hospital, St. Louis  
St. Luke's Hospital, Kansas City  
St. Luke's Hospital, St. Louis  
St. Mary's Infirmary, St. Louis  
St. Mary's Hospital, Kansas City  
50 to 100 beds  
Boone County Hospital, Columbia  
Frisco Employees' Hospital, Springfield  
Independence Sanitarium, Independence  
Parker Memorial Hospital, Columbia  
St. Francis Hospital, Cape Girardeau  
St. Francis Hospital, Maryville  
St. John's Hospital, Joplin  
St. Louis Baptist Hospital, St. Louis  
St. Mary's Hospital, Jefferson City  
\*Trinity Lutheran Hospital, Kansas City

35 to 50 beds  
Barnard Free Skin and Cancer Hospital, St. Louis  
St. Louis Maternity Hospital, St. Louis  
Wheatley Provident Hospital, Kansas City  
MONTANA  
100 or more beds  
Columbus Hospital, Great Falls  
Holy Rosary Hospital, Miles City  
Montana Deaconess Hospital, Great Falls  
Murray Hospital, Butte  
St. James Hospital, Butte  
St. Patrick's Hospital, Missoula  
St. Vincent's Hospital, Billings

50 to 100 beds  
\*Northern Pacific Beneficial Association Hospital, Glendive  
Northern Pacific Beneficial Association Hospital, Missoula  
St. Ann's Hospital, Anaconda  
\*St. John's Hospital, Helena  
St. Joseph's Hospital, Lewistown

## NEBRASKA

100 or more beds  
Bishop Clarkson Memorial Hospital, Omaha  
Nebraska Methodist Episcopal Hospital, Omaha  
Nebraska Orthopedic Hospital, Lincoln  
St. Elizabeth's Hospital, Lincoln  
St. Francis Hospital, Grand Island  
St. Joseph's Hospital, Omaha  
St. Mary's Hospital, Columbus  
University of Nebraska Hospital, Omaha  
50 to 100 beds  
Immanuel Hospital, Omaha  
\*St. Joseph's Hospital, Alliance  
Swedish Mission Hospital, Omaha  
Wise Memorial Hospital, Omaha

## NEVADA

50 to 100 beds  
Elko General Hospital, Elko  
St. Mary's Hospital, Reno  
35 to 50 beds  
Steptoe Valley Hospital, East Ely

## NEW HAMPSHIRE

100 or more beds  
St. Joseph's Hospital, Nashua  
50 to 100 beds  
\*Claremont Hospital, Claremont  
Elliott Community Hospital, Keene  
Elliott Hospital, Manchester  
\*Laconia Hospital, Laconia  
\*Margaret Pillsbury General Hospital, Concord  
Mary Hitchcock Memorial Hospital, Hanover  
Nashua Memorial Hospital, Nashua  
Notre Dame Hospital, Manchester  
\*Portsmouth Hospital, Portsmouth  
Sacred Heart Hospital, Manchester

## NEW JERSEY

100 or more beds  
Alexian Brothers Hospital, Elizabeth  
All Soul's Hospital, Morristown  
Atlantic City Hospital, Atlantic City  
Bayonne Hospital and Dispensary, Bayonne  
Christ Hospital, Jersey City  
Cooper Hospital, Camden  
Elizabeth General Hospital, Elizabeth  
Englewood Hospital, Englewood  
Hackensack Hospital, Hackensack  
Jersey City Hospital, Jersey City  
Mercer Hospital, Trenton  
Monmouth Memorial Hospital, Long Branch  
Morristown Memorial Hospital, Morristown  
Mountainside Hospital, Montclair  
Muhlenberg Hospital, Plainfield  
Newark Beth Israel Hospital, Newark  
Newark City Hospital, Newark  
Newark Memorial Hospital, Newark  
Newark Presbyterian Hospital, Newark  
Orange Memorial Hospital, Newark  
\*Passaic General Hospital, Passaic  
Paterson General Hospital, Paterson  
Perth Amboy City Hospital, Perth Amboy  
St. Barnabas Hospital, Newark  
St. Elizabeth's Hospital, Elizabeth  
St. Francis Hospital, Jersey City  
St. Francis Hospital, Trenton  
St. James Hospital, Newark  
St. Joseph's Hospital, Paterson  
\*St. Gerard's Italian Hospital, Newark  
St. Mary's Hospital, Hoboken  
St. Mary's Hospital, Orange  
St. Mary's Hospital, Passaic  
St. Michael's Hospital, Newark  
St. Peter's General Hospital, New Brunswick  
\*West Jersey Homeopathic Hospital, Camden

50 to 100 beds  
Ann May Memorial Hospital, Spring Lake  
Homeopathic Hospital, Newark  
\*Hospital for Women and Children, Newark  
Mariam and Nathan Barnert Memorial Hospital, Paterson  
Middlesex General Hospital, New Brunswick  
\*Newcomb Hospital, Vineland  
Newark Eye and Ear Infirmary, Newark  
North Hudson Hospital, Weehawken  
\*Overlook Hospital, Summit  
William McKinley Memorial Hospital, Trenton

35 to 50 beds  
\*Burlington County Hospital, Mt. Holly  
NEW MEXICO  
50 to 100 beds  
St. Joseph's Hospital, Albuquerque  
\*St. Mary's Hospital, Gallup  
\*St. Mary's Hospital, Roswell  
St. Vincent's Hospital, Santa Fe

## NEW YORK

100 or more beds  
Albany Hospital, Albany  
\*Arnot-Ogden Memorial Hospital, Elmira  
Auburn City Hospital, Auburn  
Bellevue Hospital, New York City  
Beth David Hospital, New York City  
Beth Israel Hospital, New York City  
Beth Moses Hospital, Brooklyn

Binghamton Hospital, Binghamton  
Broad Street Hospital, New York City  
Bronx Hospital, New York City  
Brooklyn Hospital, Brooklyn  
Brownsville and East New York Hospital, Brooklyn  
Buffalo City Hospital, Buffalo  
Buffalo General Hospital, Buffalo  
Buffalo Hospital of Sisters of Charity, Buffalo  
Bushwick Hospital, Brooklyn  
Carson C. Peck Memorial Hospital, Brooklyn  
Children's Hospital, Buffalo  
Columbus Extension Hospital, New York City  
Community Hospital, New York City  
Coney Island Hospital, Brooklyn  
\*Crouse-Ingersoll Hospital, Syracuse  
Cumberland Street Hospital, Brooklyn  
Deaconess Home and Hospital, Buffalo  
Ellis Hospital, Schenectady  
Faxton Hospital, Utica  
Fifth Avenue Hospital, New York City  
Flower Hospital, New York City  
Flushing Hospital and Dispensary, Flushing  
Fordham Hospital, New York City  
French Benevolent Society Hospital, New York City  
Gouverneur Hospital, New York City  
Grasslands Hospital, Valhalla  
Greenpoint Hospital, Brooklyn  
Harlem Hospital, New York City  
Highlands Hospital, Rochester  
Hospital of the Good Shepherd, Syracuse  
Holy Family Hospital, Brooklyn  
House of Good Samaritan, Watertown  
Hospital for Deformities and Joint Diseases, New York City

\*Ithaca City Hospital, Ithaca  
Jewish Hospital, Brooklyn  
Jewish Maternity Hospital, New York City  
\*Jewish Memorial Hospital, New York City  
King's County Hospital, Brooklyn  
Knickerbocker Hospital, New York City  
\*Lawrence Hospital, Bronxville  
Lebanon Hospital, New York City  
Lenox Hill Hospital, New York City  
Lincoln Hospital, New York City  
Long Island College Hospital, Brooklyn  
\*Lutheran Hospital of Manhattan, New York City  
Manhattan Eye and Ear Hospital, New York City  
Mary Imogene Bassett Hospital, Cooperstown  
Memorial Hospital for Cancer and Allied Diseases, New York City  
Memorial Hospital, Albany  
Methodist Episcopal Hospital, Brooklyn  
Metropolitan Hospital, New York City  
\*Millard Fillmore Hospital, Buffalo  
Misericordia Hospital, New York City  
Mt. St. Mary's Hospital, Niagara Falls  
Mt. Sinai Hospital, New York City  
Mt. Vernon Hospital, Mt. Vernon  
Montefiore Hospital, New York City  
Nassau Hospital, Mineola, Long Island  
New Rochelle Hospital, New Rochelle  
New York City Hospital, Blackwell's Island, New York City  
New York Eye and Ear Infirmary, New York City

New York Foundling Home, New York City  
New York Hospital, New York City  
New York Infirmary for Women and Children, New York City  
New York Nursery and Child's Hospital, New York City  
New York Orthopedic Hospital, New York City  
New York Orthopedic Hospital for Children, West Haverstraw  
\*New York Polyclinic Hospital, New York City  
New York Post Graduate Hospital, New York City  
New York Hospital for Ruptured and Crippled, New York City  
New York Skin and Cancer Hospital, New York City  
Niagara Falls Memorial Hospital, Niagara Falls  
Norwegian Lutheran Deaconess Hospital, Brooklyn

Olean General Hospital, Olean  
Oneida County Hospital, Rome  
Park Avenue Clinical Hospital, Rochester  
Presbyterian Hospital, New York City  
Prospect Heights Hospital, New York City  
Rochester General Hospital, Rochester  
Rochester Homeopathic Hospital, Rochester  
Roosevelt Hospital, New York City  
\*Sailors Snug Harbor Hospital, New Brighton  
St. Catherine's Hospital, Brooklyn  
St. Elizabeth's Hospital and Home, Utica  
St. Francis Hospital, New York City  
St. John's Brooklyn Hospital, Brooklyn  
St. John's Hospital, Long Island  
\*St. John's Riverside Hospital, Yonkers  
\*St. Joseph's Hospital, Syracuse  
St. Luke's Hospital, New York City  
\*St. Luke's Hospital, Newburgh  
\*St. Luke's Hospital, Utica  
St. Mark's Hospital, New York City  
\*St. Mary's Maternity Hospital, Buffalo  
St. Mary's Free Hospital for Children, New York City

St. Mary's Hospital, Brooklyn  
 St. Mary's Hospital, Rochester  
 St. Peter's Hospital, Albany  
 St. Peter's Hospital, Brooklyn  
 St. Vincent's Hospital, New York City  
 Samaritan Hospital, Troy  
 Saratoga Hospital, Saratoga Springs  
 Sloan Hospital for Women, New York City  
 Soldiers and Sailors Memorial Hospital, Utica  
 Staten Island Hospital, Tompkinsville  
 Syracuse Memorial Hospital, Syracuse  
 The Sanitarium, Clifton Springs  
 Troy Hospital, Troy  
 United Hospital, Port Chester  
 United Israel Zion Hospital, Brooklyn  
 Vassar Brothers Hospital, Poughkeepsie  
 \*White Plains Hospital, White Plains  
 Woman's Hospital, in the State of New York, New York City  
 Wyckoff Heights Hospital, Brooklyn  
 Yonkers Homeopathic Hospital and Maternity Home, Yonkers

50 to 100 beds  
 \*Alice Hyde Memorial Hospital, Malone  
 Amsterdam City Hospital, Amsterdam  
 Anthony Brady Hospital, Albany  
 \*Aurelia Osborn Fox Memorial Hospital, Oneonta  
 Babies Hospital, New York City  
 \*Beekman Street Hospital, New York City  
 \*Bethesda Hospital, Hornell  
 \*Broad Street Hospital, Oneida  
 \*Brooklyn Eye and Ear Hospital, Brooklyn  
 \*Champlain Valley Hospital, Plattsburg  
 City Hospital, Kingston  
 Columbus Hospital, New York City  
 \*Dobbs Ferry Hospital, Dobbs Ferry  
 Emergency Hospital of Sisters of Charity, Buffalo  
 General Hospital, Syracuse  
 \*Geneva City Hospital, Geneva  
 Glens Falls Hospital, Glens Falls  
 Harbor Hospital, Brooklyn  
 Hudson City Hospital, Hudson  
 \*Italian Benevolent Hospital, New York City  
 Jamaica Hospital, Jamaica  
 \*Leonard Hospital, Troy  
 Manhattan Maternity Hospital, New York City  
 Mary Immaculate Hospital, Jamaica  
 Mary McClellan Hospital, Cambridge  
 \*Nathan Littauer Hospital, Gloversville  
 Neurological Institute, New York City  
 \*New York Ophthalmic Hospital, New York City  
 Ossining Hospital, Ossining  
 Peoples Hospital, New York City  
 Rockefeller Institute, New York City  
 Reconstruction Hospital, New York City  
 Rome Hospital, Rome  
 St. Bartholomew's Hospital, New York City  
 St. Joseph Hospital, Yonkers  
 \*St. Mary's Hospital, Amsterdam  
 St. Vincent's Hospital, West New Brighton  
 Southampton Hospital, Southampton  
 \*Swedish Hospital, Brooklyn  
 35 to 50 beds  
 Lexington Hospital, New York City  
 \*Southside Hospital, Bayshore

## NORTH CAROLINA

100 or more beds  
 \*Asheville Mission Hospital, Asheville  
 \*James Walker Memorial Hospital, Wilmington  
 Rex Hospital, Raleigh  
 \*St. Leo's Hospital, Greensboro  
 Watts Hospital, Durham  
 50 to 100 beds  
 Atlantic Coast Lines R. R. Hospital, Rocky Mount  
 \*City Hospital, Winston-Salem  
 \*French Broad Hospital, Asheville  
 Highpoint Hospital, Highpoint  
 Highsmith Hospital, Fayetteville  
 Long's Sanitarium, Statesville  
 Martin Memorial Hospital, Mt. Airy  
 \*Mercy General Hospital, Charlotte  
 \*Meriwether Hospital, Asheville  
 North Carolina Orthopedic Hospital, Gastonia  
 Parkview Hospital, Rocky Mount  
 Pitt Community Hospital, Greenville  
 Pittman Hospital, Fayetteville  
 Rutherford Hospital, Rutherfordton  
 \*Salisbury Hospital, Salisbury  
 35 to 50 beds  
 \*Biltmore Hospital, Biltmore  
 Bullock Hospital, Wilmington  
 Cumberland General Hospital, Fayetteville  
 \*Edgecomb General Hospital, Tarboro  
 Lawrence Hospital, Winston-Salem  
 \*More Heiring Hospital, Wilson  
 Parrott Memorial Hospital, Winston  
 Richard Baker Hospital, Hickory  
 Wesley Long Memorial Hospital, Greensboro

## NORTH DAKOTA

100 or more beds  
 Bismarck Evangelical Deaconess Hospital, Bismarck  
 Grand Forks Deaconess Hospital, Grand Forks  
 St. Alexis Hospital, Bismarck  
 \*St. John's Hospital, Fargo  
 St. Luke's Hospital, Fargo

50 to 100 beds  
 \*St. Joseph's Hospital, Minot  
 St. Michael's Hospital, Grand Forks

## OHIO

100 or more beds  
 Alliance Hospital, Alliance  
 Aultman Hospital, Canton  
 Bethesda Hospital, Cincinnati  
 Christ Hospital, Cincinnati  
 Cincinnati General Hospital, Cincinnati  
 City Hospital, Akron  
 Cleveland City Hospital, Cleveland  
 \*Cleveland Maternity Hospital, Cleveland  
 \*Glenview Hospital, Cleveland  
 Good Samaritan Hospital, Cincinnati  
 \*Good Samaritan Hospital, Zanesville  
 Grant Hospital, Columbus  
 Hawkes Hospital of Mt. Carmel, Columbus  
 Huron Road Hospital, Cleveland  
 Jewish Hospital, Cincinnati  
 Lakeside Hospital, Cleveland  
 Lucas County Hospital, Toledo  
 Lutheran Hospital, Cleveland  
 Massillon City Hospital, Massillon  
 Mercy Hospital, Hamilton  
 Mercy Hospital, Toledo  
 Miami Valley Hospital, Dayton  
 Mt. Sinai Hospital, Cleveland  
 \*Peoples Hospital, Akron  
 St. Alexis Hospital, Cleveland  
 \*St. Ann's Infant Asylum and Maternity Hospital, Cleveland  
 \*St. Elizabeth's Hospital, Dayton  
 St. Elizabeth's Hospital, Youngstown  
 \*St. Francis Hospital, Columbus  
 St. John's Hospital, Cleveland  
 \*St. Joseph's Hospital, Lorain  
 St. Luke's Hospital, Cleveland  
 St. Mary's Hospital, Cincinnati  
 St. Rita's Hospital, Lima  
 St. Vincent's Hospital, Cleveland  
 St. Vincent's Hospital, Toledo  
 Springfield City Hospital, Springfield  
 Starling-Loring University Hospital, Columbus  
 Toledo Hospital, Toledo  
 Youngstown Hospital, Youngstown  
 White Cross Hospital, Columbus  
 Woman's Hospital, Cleveland  
 50 to 100 beds  
 Bellaire City Hospital, Bellaire  
 Children's Hospital, Cincinnati  
 Children's Hospital, Columbus  
 Deaconess Hospital, Cincinnati  
 \*Fairview Hospital, Cleveland  
 Flower Hospital, Toledo  
 Good Samaritan Hospital, Sandusky  
 \*Hospital Clinic Company, Cleveland  
 Lakewood Hospital, Lakewood  
 Lima City Hospital, Lima  
 Mansfield General Hospital, Mansfield  
 Martin's Ferry Hospital, Martin's Ferry  
 Mary Day Nursery and Children's Hospital, Akron  
 Maternity and Children's Hospital, Toledo  
 \*Memorial Hospital, Fremont  
 Mercy Hospital, Columbus  
 Mercy Hospital, Canton  
 Newark City Hospital, Newark  
 \*Ohio Valley Hospital, Steubenville  
 Robinwood Hospital, Toledo  
 Salem Hospital, Salem  
 Schirman Hospital, Portsmouth  
 Seton Hospital, Cincinnati  
 Warren City Hospital, Warren

## OKLAHOMA

100 or more beds  
 St. Anthony's Hospital, Oklahoma City  
 State University Hospital, Oklahoma City  
 50 to 100 beds  
 \*El Reno Sanitarium, El Reno  
 \*Morningside Hospital, Tulsa  
 \*Wesley Hospital, Oklahoma City  
 35 to 50 beds  
 \*Ponca City Hospital, Ponca City

## OREGON

100 or more beds  
 Emanuel Hospital, Portland  
 Good Samaritan Hospital, Portland  
 Multnomah County Hospital, Portland  
 Portland Sanitarium, Portland  
 St. Vincent's Hospital, Portland  
 50 to 100 beds  
 Mercy Hospital, Eugene  
 Portland Surgical Hospital, Portland  
 Sacred Heart Hospital, Medford  
 St. Mary's Hospital, Astoria

## PENNSYLVANIA

100 or more beds  
 Abington Hospital, Abington  
 Allegheny General Hospital, Pittsburgh  
 Allentown Hospital, Allentown  
 Altoona Hospital, Altoona  
 Braddock General Hospital, Braddock  
 Bryn Mawr Hospital, Bryn Mawr  
 Chester County Hospital, West Chester  
 Chester Hospital, Chester  
 Chestnut Hill Hospital, Philadelphia  
 Children's Homeopathic Hospital, Philadelphia  
 Clearfield Hospital, Clearfield  
 Columbia Hospital, Pittsburgh  
 Conemaugh Valley Memorial Hospital, Johnstown

Easton Hospital, Easton  
 Elizabeth Steel Magee Hospital, Pittsburgh  
 Frankford Hospital, Philadelphia  
 George F. Geisinger Hospital, Danville  
 Germantown Dispensary and Hospital, Philadelphia  
 Hahnemann Hospital, Scranton  
 Hahnemann Medical and Surgical Hospital, Philadelphia  
 Hamot Hospital, Erie  
 Harrisburg Hospital, Harrisburg  
 Hazleton State Hospital, Hazleton  
 Homeopathic Medical and Surgical Hospital, Pittsburgh  
 Hospital of the Protestant Episcopal Church, Philadelphia  
 Hospital of the University of Pennsylvania, Philadelphia  
 Hospital of the Women's Medical College, Philadelphia  
 J. Lewis Crozier Hospital, Chester  
 Jefferson Hospital, Philadelphia  
 \*Jewish Hospital, Philadelphia  
 Lancaster General Hospital, Lancaster  
 Lankenau Hospital, Philadelphia  
 Medico Chirurgical Hospital, Philadelphia  
 Memorial Hospital, Roxborough  
 \*Mercy Hospital, Altoona  
 Mercy Hospital, Johnstown  
 Mercy Hospital, Philadelphia  
 Mercy Hospital, Pittsburgh  
 Mercy Hospital, Wilkes-Barre  
 Methodist Episcopal Hospital, Philadelphia  
 Misericordia Hospital, Philadelphia  
 Moses Taylor Hospital, Scranton  
 Mt. Sinai Hospital, Philadelphia  
 Passavant Hospital, Pittsburgh  
 Pennsylvania Hospital, Philadelphia  
 Philadelphia General Hospital, Philadelphia  
 Philadelphia Polyclinic Hospital, Philadelphia  
 Pittsburgh Hospital, Pittsburgh  
 Pottsville Hospital, Pottsville  
 Presbyterian Hospital, Philadelphia  
 Presbyterian Hospital, Pittsburgh  
 Reading Hospital, Reading  
 Robert Packer Hospital, Sayre  
 Sacred Heart Hospital, Allentown  
 St. Agnes Hospital, Philadelphia  
 St. Francis Hospital, Pittsburgh  
 St. John's General Hospital, Pittsburgh  
 St. Joseph's Hospital, Lancaster  
 St. Joseph's Hospital, Philadelphia  
 St. Joseph's Hospital, Pittsburgh  
 St. Joseph's Hospital, Reading  
 \*St. Joseph's Infant and Maternity Hospital, Scranton  
 St. Luke's Hospital, South Bethlehem  
 St. Margaret's Hospital, Pittsburgh  
 St. Mary's Hospital, Philadelphia  
 St. Vincent's Hospital, Erie  
 Samaritan Hospital, Philadelphia  
 Scranton State Hospital, Scranton  
 South Side Hospital, Pittsburgh  
 Uniontown Hospital, Uniontown  
 Washington Hospital, Washington  
 West Philadelphia Hospital for Women, Philadelphia  
 Western Pennsylvania Hospital, Pittsburgh  
 \*Westmoreland Hospital, Greensburg  
 Wilkes-Barre City Hospital, Wilkes-Barre  
 Wills Hospital, Philadelphia  
 Women's Homeopathic Hospital, Philadelphia  
 Women's Hospital, Philadelphia  
 York Hospital and Dispensary, York  
 50 to 100 beds  
 Annie M. Warner Hospital, Gettysburg  
 Bainbridge Private Hospital, Philadelphia  
 Beaver Valley General Hospital, New Brighton  
 \*Carlisle General Hospital, Carlisle  
 Children's Hospital, Philadelphia  
 Children's Hospital, Pittsburgh  
 Citizens General Hospital, New Kensington  
 \*Columbia Hospital, Columbia  
 Cottage State Hospital, Blossburg  
 DuBois Hospital, DuBois  
 Eye and Ear Hospital, Pittsburgh  
 \*Frederick Douglass Memorial Hospital, Philadelphia  
 Good Samaritan Hospital, Lebanon  
 Homeopathic Hospital, West Chester  
 Howard Hospital, Philadelphia  
 \*Indiana Hospital, Indiana  
 J. C. Blair Memorial Hospital, Huntington  
 Jewish Maternity Hospital, Philadelphia  
 Joseph Price Memorial Hospital, Philadelphia  
 \*Kane Summitt Hospital, Kane  
 \*Lock Haven Hospital, Lock Haven  
 \*Montgomery Hospital, Norristown  
 Montefiore Hospital, Pittsburgh  
 \*New Castle Hospital, New Castle  
 Oil City Hospital, Oil City  
 Palmerton Hospital, Palmerton  
 Philadelphia Lying-in Charity Hospital, Philadelphia  
 Pittston Hospital, Pittston  
 \*Polyclinic Hospital, Harrisburg  
 Providence Hospital, Beaver Falls  
 St. Luke's Homeopathic Hospital, Philadelphia  
 St. Vincent's Hospital, Philadelphia  
 Sewickley Valley Hospital, Sewickley  
 Shamokin Hospital, Shamokin  
 \*State Hospital of Nanticoke, Nanticoke



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## The Use of Gelatine in Diabetes

**I**N ALL DISEASES in which the cure centers upon the successful assimilation of a prescribed diet, Knox Sparkling Granulated Gelatine has been found an agent of inestimable value.

It has been shown by a long series of experiments with charted feedings that quite aside from its direct contribution of the natural amino acid Lysine, Knox Sparkling Gelatine promotes the digestion of other foods combined with it by its protective colloidal ability.

It usually permits foods otherwise disturbing, to be assimilated without effort and in the quantities desired.

Doctors are using this pure granulated gelatine freely in cases of Diabetes, Chronic Indigestion, and Mal-nutrition. Gelatine dissolved and added to milk in the proportion of one per cent (1 level tablespoonful) to a quart increases the nutriment obtainable from the milk by 23%.

A number of special recipes for Diabetic Diets have been prepared by a recognized authority and will be mailed to doctors and hospitals upon request together with a scientific report on the Health Value of Gelatine.

In addition to the family size packages of "Plain Sparkling" and "Sparkling Acidulated" (which latter contains a special envelope of lemon flavoring,) Knox Sparkling Gelatine is put up in 1 and 5 pound cartons for special hospital use. A trial package at 80c the pound will be sent on request.

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 Hamilton General Hospital, Hamilton  
 Hotel Dieu, Kingston  
 Hotel Dieu, Windsor  
 General Hospital, Kingston  
 \*McKellar General Hospital, Ft. William  
 Ottawa General Hospital, Ottawa  
 Protestant General Hospital, Ottawa  
 St. Joseph's Hospital, Hamilton  
 St. Joseph's Hospital, London  
 St. Joseph's Hospital, Port Arthur  
 St. Joseph's Hospital, Sudbury  
 St. Luke's General Hospital, Ottawa  
 St. Michael's Hospital, Toronto  
 Sick Children's Hospital, Toronto  
 Western Hospital, Toronto  
 Victoria Hospital, London  
 Wellesley Hospital, Toronto  
 50 to 100 beds  
 \*General Hospital, Belleville  
 General Hospital, Sault Ste Marie  
 \*Ningara Falls Memorial Hospital, Niagara Falls  
 Nicholls Hospital, Peterboro  
 Oshawa General Hospital, Oshawa  
 Owen Sound General and Marine Hospital, Owen Sound  
 Public Hospital, Smith Falls  
 St. Francis Hospital, Smith Falls  
 St. Joseph's Hospital, Peterboro  
 \*Welland County Hospital, Welland  
 Women's College Hospital, Toronto

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 Prince Edward Island Hospital, Charlottetown  
 Princes County Hospital, Summerside  
 QUEBEC  
 100 or more beds  
 Children's Memorial Hospital, Montreal

De La Misericordia Hospital, Montreal  
 General St. Vincent Hospital, Sherbrooke  
 Hotel Dieu, Montreal  
 Jeffrey Hale's Hospital, Quebec  
 Montreal General Hospital, Montreal  
 Notre Dame Hospital, Montreal  
 Royal Victoria Hospital, Montreal  
 Sainte Justine Pour Les Enfants, Montreal  
 Western Hospital, Montreal

#### 50 to 100 beds

\*Homeopathic Hospital, Montreal  
 Montreal Foundling and Baby Hospital, Montreal  
 Montreal Maternity Hospital, Montreal  
 \*St. Francois d'Assise, Quebec  
 \*Sherbrooke Hospital, Sherbrooke

#### SASKATCHEWAN

#### 100 or more beds

Grey Nun's Hospital, Regina  
 \*Moose Jaw General Hospital, Moose Jaw  
 St. Paul's Hospital, Saskatoon  
 Saskatoon City Hospital, Saskatoon

#### 50 to 100 beds

Holy Family Hospital, Prince Albert  
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 Providence Hospital, Moose Jaw  
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 National Military Home, Dayton, Ohio  
 National Military Home, Milwaukee, Wisconsin  
 National Military Home, Togus, Maine  
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 Marine Hospital, No. 10, Key West, Florida  
 Marine Hospital, No. 11, Louisville, Kentucky  
 Marine Hospital, No. 15, Pittsburgh, Pennsylvania  
 Marine Hospital, No. 20, Savannah, Georgia  
 Marine Hospital, No. 21, Stapleton, New York  
 Marine Hospital, No. 43, Ellis Island, New York  
 Marine Hospital, No. 66, Carville, Louisville  
 Marine Hospital, No. 70, New York, New York  
 Marine Hospital, No. 12, Memphis, Tennessee  
 Marine Hospital, No. 13, Mobile, Alabama  
 Marine Hospital, No. 14, New Orleans, Louisiana  
 Marine Hospital, No. 18, St. Louis, Missouri  
 Marine Hospital, No. 22, Norfolk, Virginia  
 Marine Hospital, No. 5, Chicago, Illinois  
 Marine Hospital, No. 17, Pt. Townsend, Washington

Errata: The names of the following hospitals were inadvertently omitted from the approved list published October 1, 1924.

#### 100 or more beds

\*Bethesda Hospital, Zanesville, Ohio.  
 Cleveland Clinic Hospital, Cleveland, Ohio.

#### 50-100 beds

Jane C. Stormont Hospital, Topeka, Kansas.  
 St. Anthony's Hospital, Amarillo, Texas.

### A. M. A. DISPLAYS HOSPITAL DATA

Superintendents and others who are interested in the success of their hospitals made use of the opportunity to meet the representatives of the Council on Medical Education and Hospitals, and to learn how hospitals may be placed on the council's list of hospitals accredited for interns and what this means in the problem of securing interns, at the booth of the American Medical Association. The record of the council's achievement in the standardization of medical colleges, reducing the number of colleges by half but more than doubling their efficiency, is well-known history.

The bureau of health and public instruction of the A. M. A. was there with *Hygeia*, the American Medical Association's new journal of health for lay readers. A splendid display of colored health posters selected from the 4492 posters painted by high school pupils in the *Hygeia* contest, were of special interest to health instructors, school nurses, and other public health workers. There were also the bureau's baby health posters and health pamphlets that are used for educational purposes.

Without doubt the most spectacular of all the work of the American Medical Association is that of its bureau of investigation in its thorough and fearless exposure of quacks, frauds, nostrums, and spurious patent medicines.

The A. M. A. is now revising its list of hospitals for a new edition of the medical directory and gathering data for the hospital number of *The Journal of the American Medical Association*.

### ANNUAL BANQUET SESSION A SUCCESSFUL INNOVATION

One of the successful innovations of the conference was the annual banquet and dance, held in the ball room of the Hotel Statler, Tuesday evening, October 7. The success of the banquet session was due partly to the foresight of the committee which placed this session near the beginning of the conference instead of upon the closing night, as has been the custom in the past.

The decorations of the ballroom with British and American flags as well as the singing of the Anglo-American hymn and other international songs gave a truly cosmopolitan flavor to the banquet.

The dinner session terminated with dancing and card games which formed the evening's entertainment.

### NURSES' LUNCHEONS SPONSORED BY NEW YORK GROUP

The nursing committee, under the chairmanship of Mrs. Anne L. Hansen, R.N., president of the New York State Nurses' Association arranged for two nurses' luncheons on Tuesday and Wednesday at 1 p. m. These luncheons were held in the officers mess hall of the armory.

At the Tuesday luncheon, Miss Janet Geister, R.N., Committee on Dispensary Development, New York, N. Y., spoke on "The Proper Relationships of Hospital, Dispensary and Field Nursing."

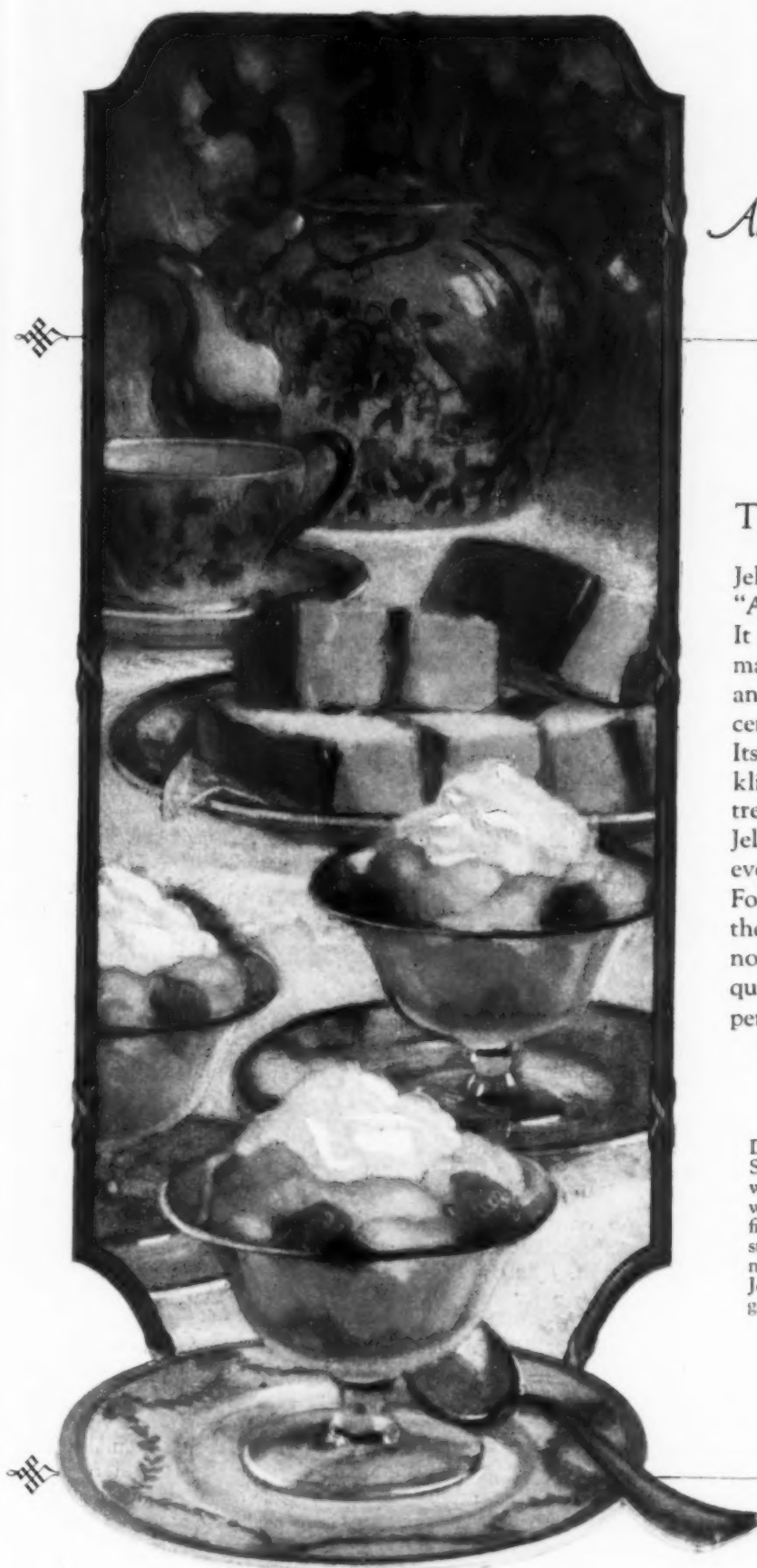
The program for the Wednesday luncheon was:

"What is a General Hospital?" by Dr. Walter S. Goodale.

"Can Nurses be Trained in Anything but a General Hospital?" by Alice S. Gilman, R.N., secretary state board of nurse examiners.

### A. C. OF S. BOOTH DISPLAYS HOSPITAL STANDARDIZATION DATA

The American College of Surgeons' booth was the scene of much interest and attention during the conference. This booth was arranged in such a way that the work of the college in the past was comprehensively demonstrated and a great deal of information presented on the subject of hospital standardization. It was particularly of note that all the hospitals represented are taking an increased interest in the work of the American College of Surgeons for hospital betterment. The hospital information and service department feature was well demonstrated to the various visitors.



# JELL-O

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Jell-O is perhaps best known as "America's most famous dessert." It is a light but nourishing sweet—made from purest gelatin, cane sugar and fruit juices. For the convalescent, or invalid, it is unsurpassed. Its tempting flavor and clear, sparkling color provides a delightful treat for the "finicky" appetite. Jell-O, of course, is always and everywhere a favorite with children. For hospitals and other institutions, the large size package is most economical, its contents making four quarts, enough for forty to fifty persons.



### BERRY FRAPPE

Dissolve a package of Raspberry or Strawberry Jell-O in a pint of boiling water. When cold and still liquid whip and pile into frappe glasses partly filled with crushed fresh raspberries or strawberries. A cup of whipped cream may be folded into the whipped Jell-O if desired. Canned berries are good when fresh fruit is out of season.



## NURSING AND THE HOSPITAL

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### METHODS OF SECURING COOPERATION FROM AND THROUGH THE NURSING STAFF

BY DAISY DEAN URCH, DIRECTOR OF SAN FRANCISCO HOSPITAL SCHOOL OF NURSING, SAN FRANCISCO, CALIF.

IT IS said that when one has a problem to solve, the first thing to do is to find out what has already been done in that particular field, that is, study the history of what has been accomplished, how it was accomplished, select the factors which made for success, eliminate the ones which made for failure, go to the sciences for help and then think through a plan that will work better than any one that has been tried out before.

I have tried to apply this rule to the subject given me to discuss today, but I find it very difficult. Looking back upon the successes in our field, that I have been so fortunate as to witness, I find it no easy task to analyze the "how" and the "why" of the factor which made for success. This problem does not lend itself to the usual scientific analysis, and resulting solution. Even the present very practical psychology does not provide an adequate yard stick with which to measure such indefinable forces as many of those which are conducive to successful cooperation amongst a group of people working together.

#### Profession Deep-Rooted in Tradition

Then, too, we have the complication of dealing with a profession which has its roots, in, and still clings to, many of the practices of the military and religious groups of the past. But most certainly the solution lies largely in the understanding of human nature and the application of this knowledge to our particular problem. We must go to the field of psychology and sociology and physiology for help, but we must not fail to keep our feet on the ground and use plenty of plain common sense in applying these sciences. Whenever I attempt to make a practical application of the teachings of one of these sciences, I am reminded of the story I heard Dean Russell relate. A small boy's father sent him in search for a runaway horse. When the boy returned leading the horse, his father asked, "How did you know where to look for him?" The boy replied, "I just thought of what I would have done had I been a horse, and he had done it." There is much food for thought in this little story. It is helpful to sit down and think of what one would do if one were a member of the nursing staff—to let one's imagination play about the things which make an appeal that would result in an atmosphere con-

ducive to effective cooperation. In psychological terms, to think out the stimulation that leads to the response, cooperation.

Recognizing the fact that success in getting the cooperation of other people lies in the ability to understand human nature—to gauge the state of mind of the individuals concerned—the ability to project oneself into their places and, like the small boy, think what would appeal to you, our first problem then is to get the point of view of the members of the staff. For, to quote William Heard Kilpatrick, "we must meet people where they are in order to lead them to the place where we want them to be." One of the most fruitful sources of getting another's point of view lies in conferences in which there is freedom of discussion.

#### No Time to Discuss Problems

We often fail because we do not talk things over enough. We need to get together again and again and again and to "thrash out" our problems over and over and over. I believe that we nurses in our mad rush to get all the work we find laid out for us done, fail signally in that we do not have time to discuss our problems sufficiently, to really think out where we are, and what we want to do. There should be time for individual conference with each member of the staff; time to listen sympathetically to her problems and plans, and to deal with them in a manner which is satisfactory to her as well as to us.

It is also exceedingly desirable that in some manner we instill into the members of the staff a great desire to help carry out the ideals of the institution; that we fire them with an enthusiasm for their work; give them a real live purpose, toward which to strive; a vision to lead them on to better work. We need to build up a morale, an esprit de corps that will carry them through the daily routine,—that will cause them to overlook the petty trials, the small annoyances, that are bound to come each day. If one can only get under their skins (if I may so express myself) and plant there an abiding purpose, the battle is really won. After that it is fairly easy to maintain the morale. When we are all working for the same thing, the methods will come easily.

William James says, "What determines ultimate efficiency? What you really wish exclusively. In almost

\*Read before the convention of the California State Nurses' Association, Pasadena, May, 1924.



Mantetsu General Hospital, Dairen, South Manchuria. Designed by the South Manchuria Railway Company under the direction of Messrs. T. Onogi and O. Oka. Crane plumbing and heating materials are being installed by the Asia Engineering Corporation, of Shanghai, China.

## ASIA LOOKS TO CRANE FOR MODERN PLUMBING

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pointments, it will come up to the highest standards of American hospital practice. It is significant that for this notable hospital, Crane plumbing fixtures and Crane piping and heating materials were the first choice of the men entrusted with its design.

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Crane Surgeon's Wash-up Sink.

any subject your passion for the subject will save you. What tells in life is the whole mind working together." If we can give to our staff a passion for their jobs, get their whole minds working together for the good of the profession, then indeed will they work together with us. Then they will each have a "self-starter." Then and only then will interested and intelligent co-operation follow. Witness what happened during the war. With the passion to "win the war" in the hearts of each and every person, how very easy it was to work together. Surely the work we are doing now is just as important and should arouse as much enthusiasm. John Dewey says that we should "work from the inside to release potentialities, not from the outside to impose conventionalities." Is it not true that too often there is a tendency on our part to impose our will upon the members of the staff, rather than to win their whole-hearted spontaneous co-operation. It is so much easier to say "You do this or you do that," and they must do it or lose their positions, but it doesn't pay. We can never win real cooperation in that way. It is easier to rule in an autocracy than in a democracy, but you never arrive at a desirable destination. If one cannot convert the members of the staff to a belief in the worthiness of the policies of the institution—to have faith in it—she is doomed to failure. The old saying, "You can put a man in a penitentiary but you cannot make him penitent" is very true. If we cannot arrive at a stage where we are all working in a democratic way for a common purpose, cooperation will be nil.

#### Military Discipline—A Drawback

I think we all agree that our profession has suffered in the past because of the military influence which has made for blind unquestioning obedience on the part of all below us in authority. The danger here is in applying a false standard of efficiency—of thinking that we have cooperation when our orders are carried out. That is not enough. Only when there is real active initiative from all concerned do we secure cooperation that is of real lasting value—that leads to the most effective work from the whole group.

How are we going to inculcate into the hearts of our helpers this appreciation for our policies—this appreciation which will make our cause their cause, and will result in us all working most earnestly for the same purpose? Not so easy to explain, yet not always so difficult to accomplish. We have all seen it done. Let us go back to our first thought that by discussion do we come to understand each other. Herein will lie much of our success. Through discussion we not only get their point of view but they get ours. The psychologists tell us that appreciation is taught mainly by exposing the individuals to people who like the things we wish the people to like, and by attaching satisfaction to the experiences connected with appreciating. Let us apply this rule to our problems, and we see that the leader herself should have a sincere liking for and faith in her institution, and should not fail to reward others who do likewise. By reward I mean not only money reward but honor reward, and praise, and credit for accomplishment, and appreciation, and a sense of security in position, and promotion, and sufficient help so that satisfactory work can be done. We never grow too old to get real pleasure out of the feeling that an honor has been conferred upon us and that our work is appreciated.

Bonser says, "Our appreciations are the cumulative results of many experiences of the same kind, each of

which gave a large degree of satisfaction; therefore leaving a tendency for more activity of the same kind." Thus the supervisor who gets satisfaction out of her "job" does it well and thus gets more satisfaction and tries to do it better and gets still more satisfaction and thus she goes on around and around in a "beneficent cycle." Who is it that wants to go away and take a course to prepare herself to do better work? Always the member of the staff who is doing the best piece of work. She has acquired the habit of improving herself and she wants the satisfaction of improving herself still more. No danger of her settling down on her job and watching the clock. Such a supervisor should be encouraged in every way to keep on growing and improving. She is amongst the ones who actively and spontaneously work with us. Her enthusiasm is very apt to permeate the whole group. One or two such fine women will often revolutionize a whole institution.

#### Responsibility Promotes Cooperation

Now, having fired the members of the staff with a zeal for the institution, having put one big common purpose in their souls, how are we going to assist them in becoming effective cooperators? First of all I believe we should place as much responsibility on each one as she is able to carry and as she grows let more and more responsibility flow to her. By all means keep her growing. And as far as possible, let each and every one carry out without interference her own ideas. Let her feel that she plays an important part in the affairs of the school. Give her an opportunity to express herself, to enlarge her powers, to exercise her abilities, to do creative work. The committee on the training of hospital executives called together by the Rockefeller Foundation say that the "chief function of a hospital executive is to create an environment conducive to the spontaneous creative expression of the groups working within the organization." I heartily agree with them. I adopt it as a text for this paper. Our job is to help, guide, direct, and correct, and foster enthusiasms, and revive lost interest, but we must not disregard the right of each individual to think for herself and to plan for herself; to reach her highest possibilities in her field. Let her search out new and better ways of accomplishing her purposes (which are our purposes). Allow her the joy of thinking ahead and seeing her dreams come true. The inspiration of accomplishment will do much toward relieving the tedium of what might otherwise be heavy days:

"In happy hours, when the imagination  
Wakes like a wind at midnight and the soul  
Trembles in all its leaves, it is a joy  
To be uplifted upon its wings and listen  
To the prophetic voices in the air  
That call us onward. Then the work we do  
Is a delight and the obedient hand  
Never grows weary."

The psychologists tell us we grow tired, not so much from overwork, as through lack of interest. Interest keeps alive so long as there is joy in accomplishing what one wishes to do.

#### Recreation in Work

Not long ago, I heard a Y. W. C. A. leader who was lecturing on recreation for professional women say, "The best recreation for any person to take is to enjoy her own job." In other words, to make play out of work. And work becomes play when one has a real urge to do it and has an opportunity to do some real thinking.

# The Hospital and Acidosis

THE community health protection given by the hospital and its out-patient department, may well include education of the public toward the prevention as well as the correction of acidosis.

Acidosis is a forerunner of so many serious organic troubles that its correction or prevention comes naturally within the field of the health protection service which today is generally accepted as a part of the hospital's function. Furthermore acidosis becomes more particularly a problem of the hospital because so frequently the condition is recognized for the first time when the patient enters the institution for diagnosis and treatment of some other ailment.

Whatever may be the underlying cause the simple corrective treatment here discussed should be considered by those responsible for the treatment and care of patients in hospitals and similar institutions.

The increasing use of sodium bicarbonate by the public to control "acid stom-

ach" should be considered in this connection. Only a part of the bicarbonate is effective and that portion which produces carbon dioxide may be seriously detrimental.

Phillips' Milk of Magnesia being free from carbonates does not distend the stomach nor cause flatulence of the lower intestinal tract. Its antacid action is pronounced. A given quantity of Phillips' Milk of Magnesia neutralizes almost three times as much acid as a saturated solution of sodium bicarbonate and nearly fifty times as much as lime water. Further it has the additional merit of being laxative, a quality of importance here since constipation is so frequently the underlying cause of hyperacidity.

## DOSAGE

The usual dose of Phillips' Milk of Magnesia, as an antacid, ranges from one teaspoonful (4 c. c.) to one tablespoonful (16 c. c.). This amount should be mixed with an equal portion of cold water or milk and given half an hour after meals.

For its laxative effect, the adult dose is one to two fluid ounces (30 to 60 c. c.). The aperient action may be facilitated by giving the juice of lemon, lime or orange, half an hour thereafter.

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On the other hand, each and every member of the staff must help also. There must be a responsible share on her part. After all, each one of us must work out her own salvation. As Croly says, "Power and opportunity enjoyed must be earned and must continue to be earned." She must have the will to keep growing in her job—to get the spirit of service—the spirit of service which engenders helpfulness and professional pride in work, which causes one to forget self and identify oneself with a cause. The spirit of service which counts duties and obligations ahead of rights and privileges. There is a great deal to be said on the "will to make good."

### Leadership Not "Drivership" Needed

Then there is another phase which we must not overlook, namely, the right of every one to be an individual—to live her own life. We need to observe what Kilpatrick calls "respect for personality." I fear the members of our profession have often been inclined to interfere with that innate desire that most of us possess to be individuals. Take for instance the matter of "bobbed hair." I wonder if bobbed hair really does interfere with the welfare of the patients under our care, or does it somehow stir up an old prejudice which we have not succeeded in driving out of our old-fashioned souls. I do not see how we can hope for effective cooperation from and through the members of the staff unless we treat them with the same consideration that we wish others to treat us. It is leadership not drivership that we need. I wonder if we are not too prone to interfere in the personal life of our helpers. Of course we want them to be people whom the students and the public respect and have confidence in; people who live up to the standards approved by the profession, but beyond that, in my opinion, we should not go. What we really need is the spirit which makes for cooperation. Always it is the spirit which counts, and spirit is something that grows only in an atmosphere which is conducive to its growth. The cooperative spirit can grow only in an atmosphere where there is mutual respect and confidence—an atmosphere where each and every one is happy in her job.

Spirit is our most valuable asset. And the spirit of cooperation will prevail when the objectives sought have become the chief purpose of the professional lives of the staff. When, through democratic leadership we have won the confidence of our helpers, have converted them to the highest ideals, and are giving them an opportunity to do a piece of work that is satisfactory to their sense of what is right, we can hope for that spirit which wins "the everlasting team work of every blooming soul."

Without the right spirit, we will not hold the right kind of women, without the right women we cannot secure the right spirit. The sum and substance of the whole matter is "get the right spirit." Like Cato of old, who day after day arose in the Roman Senate and said "Delenda est Carthago," I reiterate, "get the right spirit."

You may have observed that I have said practically nothing about salaries or hours of work. In the East I should have said something about the latter, because we all know how overfatigue interferes with efficiency, but out here with our eight-hour law, I pass them by. I believe that salary is a negligible factor

### NEAR EAST RELIEF SCHOOL OF NURSING ESTABLISHED AT ATHENS, GREECE

The latest addition to the number of schools of nursing started in foreign countries by American nurses is



Students in the new school of nursing recently established in Athens, Greece, under the supervision of Miss Christine M. Nuno.

described in a letter from Miss Christine M. Nuno, director of nursing for the Near East Relief, Athens, Greece.

Miss Nuno writes that Greece has had no training school for nurses, and the standards of work were not of the highest. A school was started in the orphanage for the oldest girls, and those who had the best education were selected. A few had had full high school, but the education of the majority was about equivalent to that of a grammar school. These students were given eight months instruction in the care of children, and it was thought that with this instruction they could be distributed to the eleven hospitals to serve as nurses' aids. At just this time a doctor in charge of one of the surgical hospitals convinced his board that these students would serve as a nucleus for a training school. His arguments were so convincing that the school has been started.

The Near East Relief will provide the salaries of the American nurses and their interpreters, the uniforms for the students, and the present school room equipment. Hereafter the hospital will provide the uniforms, teaching equipment, and the maintenance of the students for two and one-half years.

Helen Churchill, a graduate of the Boston City Hospital School of nursing, is the superintendent of this school, and Katherine McFarland of the Philadelphia Children's Hospital, is to be the instructor. It is planned to have one of the most energetic of the Greek graduates serve as assistant to Miss Churchill so that in time she will be prepared to carry on the work among her own people.

When one reads that for the eight months during which this school has been in existence, the students have had one-half day of theory in the school room, and one-half day of work in the hospital, it seems as if the school is starting out with educational ideals that will carry it a long way.

Those who know Miss Nuno and the work she did in connection with the Atlantic Division of the American Red Cross, will not be surprised to hear that she has succeeded in establishing a school in far-away Greece. Her ability to inspire others, her willingness to attempt difficult tasks, probably account in no small measure for the successful starting of what, without doubt, is a difficult piece of work. The best wishes of all American nurses are with Miss Nuno and the other graduates who are attempting this task.

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**TUMBLERS OF ALL SIZES AND STYLES**

## DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES,  
798 Lexington Avenue, New York, N. Y.

### REORGANIZATION OF NUTRITION WORK TO SAVE FOOD WASTE IN CHILDREN'S DEPARTMENT

By BÉLA SCHICK, M.D., PROFESSOR OF PEDIATRICS, MOUNT SINAI HOSPITAL, NEW YORK, N. Y.

PHYSICIANS and nurses should not only take general care of the sick but should also pay attention to their proper nutrition. The more we concern ourselves with the question of nutrition, the more we shall realize the importance of this factor in all branches of nursing. Often the success of surgical or internal treatment is dependent upon whether or not we are able to nourish the patient properly.

The education of nurses and physicians deals only with the fundamental laws of nutrition, and little time is spent on teaching special dietetics, as in diabetes, nephritis, stomach disorders, gout, high and low caloric feeding. A more thorough detailed instruction is impossible owing to the limited time of their training. The nurse and the physician have so much to learn, that many subjects, though important, cannot be considered.

As far as the nutrition of an adult is concerned the nurse has rather an easy task. She can select the proper diet because she, herself, is an adult and can better judge of how much and what she could do in a condition similar to that of the patient. And in milder cases the instinct of an adult may be helpful in feeding. But here, also, we find by experience that physicians and nurses do not pay enough attention to nutrition.

#### Problems of Child Nutrition

The problem of nutrition in the child is more difficult and requires our full attention not only in sickness but also in convalescence and in health. The instinct or the feeling of the child and its parents is not always sufficient. The child does not know when it should stop eating. An old proverb says truly: "The eyes of a child are larger than its appetite." Everybody can remember that as a child, he or she had a disturbance of digestion after eating too much candy, ice cream, fruits and other delicacies.

The need of special prescriptions and preparation of food for infants is generally recognized and everybody admits that a special training is required for the purpose. Physicians and nurses are therefore instructed in this special part of science of nutrition, and learn how to prepare the different milk mixtures. All wards for children observe very carefully the details of feeding of infants and register in charts the intake of nutritive value and the effect of treatment. The question arises, at what time

should this exceptional arrangement be stopped? Should it be carried on only in the first twelve months of life as is now usually done? *This cannot be right.* A child of two, three and four years of age has quite a different food requirement from a child of six or seven years, and we cannot use a uniform quantitative prescription for all children. In the children's ward, the nutrition of a child over twelve months is usually left to the nurse. Medical prescriptions deal more with the quality of food than with the quantity. What is the consequence? The nurse distributes the meals ordered in the general kitchen according to her judgment. Too frequently, the portions given to the child are too big and much is left over. In wards for sick children this lack of knowledge in nutrition brings about not only damage to the sick child, but also a waste of good foodstuffs, therefore of money.

#### Waste Determined by Left-over Food

In order to determine the amount of waste on the children's wards at Mount Sinai, the left-over food at the end of a meal was weighed for a prescribed length of time.

One vertical column means one day. The whole amount

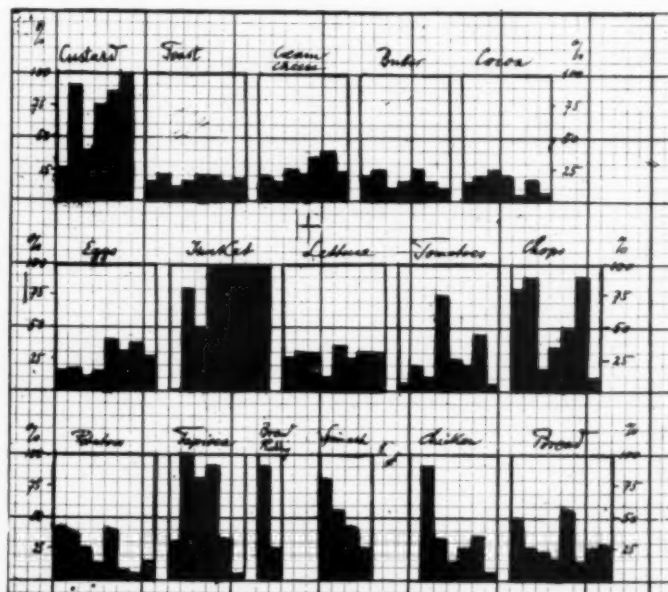


Chart I.

# Your new ally in driving coffee from the diet of children

Children				
Age		No. Exam.	Weight (lbs.)	Height (ins.)
8	Without Coffee	8	54.3	48.2
8	With Coffee	16	52.6	47.9
9	Without Coffee	11	66.0	50.7
9	With Coffee	36	58.6	49.1
11	Without Coffee	17	72.9	54.8
11	With Coffee	20	69.5	53.6
12	Without Coffee	17	78.7	55.8
12	With Coffee	17	74.0	55.4
				Grip (lbs.)
				27.9
				26.0
				33.0
				32.3
				38.7
				38.7
				45.3
				42.0

TABLE SHOWING DIFFERENCES BETWEEN CHILDREN USING COFFEE DAILY AND CHILDREN NOT USING COFFEE

EARLY in your study of medicine you learned that children should not drink coffee—that the caffeine it contains is particularly vicious in its action on the nervous system of a child.

There is a wealth of experimental data to show that what you learned is more than theory.

The chart reproduced above, presenting a study by C. K. Taylor as reported in "The Psychological Clinic," is an unusually compelling warning to fathers and mothers.

Taylor found that children who were allowed coffee regularly averaged 1.5 to 4 pounds less in weight, 0.5 to 1 inch less in height and up to 3 pounds less in hand strength when compared with children who drank no coffee at all.

According to Taylor's study, coffee had an equally appreciable effect on children's mental growth. The average ranking in lessons was 2.6% less for children who drank coffee daily. Those who drank four cups or more daily averaged as much as 9.6% less than those who drank none.

You, in common with all physicians, urge a milk diet for the average child. But you know how difficult it sometimes is to enforce your recommendation. Some children dislike the taste of milk. In others the imitative instinct makes them clamor for the beverages of their elders.

It is here that Postum can aid you. Instant Postum made with hot (not boiled) milk has all the body-building virtue of wholesome warm milk, with the distinctive Postum taste and color. Postum offers you an excellent vehicle for the undiminished food value of milk.

Postum today is the choice of 2,000,000 American families who bar drugged beverages from their tables. They like its distinctive Postum taste, and its ingredients, whole wheat and bran.

Postum is whole wheat and bran, skillfully roasted, with a little sweetening. Much of Postum's popularity springs from the fact that thousands of physicians know Postum and endorse it.

POSTUM CEREAL CO., INC., BATTLE CREEK, MICH.

*We will be glad to send the physician who addresses us a special gift package containing a full-size package of Instant Postum, together with samples of other Post Health Products.*

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When using advertisements see Classified Index, also refer to YEAR BOOK.

of different dishes offered to the children is noted as 100 per cent. No color means the food eaten; black, the percentage refused, and therefore wasted food. We found expensive foodstuffs like junkets and custards were refused on some days entirely or almost entirely. But even of customary daily foods like cocoa, butter and eggs, the waste amounted to from 20 to 25 per cent. This waste was found only in distribution of meals ready for serving. How much besides this was wasted in the general kitchen in preparing the food was not known. Probably it was at least as great if not greater. With a financial outlay of \$10,000 for food annually, 20 per cent waste would aggregate \$2,000, money which, I am sure, could be used for better purposes.

Who is responsible for this situation? Not the nurses. The responsibility rests on us physicians, who do not care enough about the feeding of children beyond infancy, and who have not a certain system for prescribing nutritive values, but leave this to the feeling of the nurse without teaching the nurse what she should do.

I asked for a system in preparing and distributing meals in my department. What system should be used is a matter open for discussion. I followed the Pirquet system which allows a simple, individual prescription for each child in portions of 100 grams milk value = 67 calories (called 1 hektionem). The recipes in the kitchen are also to be made of 67 calories = 100 grams milk value (1 hektionem). As long as our general kitchens are under supervision of leaders who are not scientifically educated, it is impossible to expect the required scientific cooperation from this side. Therefore, I asked to have our service from the special diet kitchen, which until now was only used for special diets. This kitchen is progressive. It is supervised by Miss Lulu G. Graves who is familiar with medical prescriptions.

We determine at first the food requirement for each child separately, according to the sitting height squared and get the figures in hektionem portions, (15, 20, 25, 30, 35, 40, etc.). The whole food requirement for twenty-four hours is divided in four meals: three chief meals at 7 a. m., 12 and 5 p. m., one small luncheon, a three hektionem portion, at ten o'clock in the forenoon. This small luncheon is the same for all children in order to make the distribution in our wards easier. (For details see Pirquet system of nutrition.)\*

Portions consists, for instance, of:

- 1 portion of milk—100 grams.
- 1 portion of Zwiebach—20 grams.
- 1 portion of butter—8½ grams.

If we have fifteen children of different ages and therefore different food requirement for twenty-four hours, all these fifteen children get for this luncheon the same meal. We require for these fifteen children:

- Milk—15 x 100 grams = 1500 grams.
- Zwiebach—15 x 20 grams = 300 grams.
- Butter—15 x 8½ grams = 127.5 grams.

The rest of the calculated amount of portions for twenty-four hours is divided by three and distributed on the other three meals in about equal parts, as follows:

1 portion = 100 gm. milk value = 67 calories (1 hektionem).

Portions for 24 hours:

	15	20	25	30	35	40	45
7 a. m. ....	4	6	7	9	11	12	14
10 a. m. ....	3	3	3	3	3	3	3
12 m. ....	4	6	8	9	11	13	14
5 p. m. ....	4	5	7	9	10	12	14

Luncheon

The composition of these meals is given in the following chart:

Class	I-a	II	II-a	III	III-a	IV	IV-a	Summary
Name of Patients								
Milk	2	2	2	2	3	3	3	
Cocoa & Sugar	1	1	1	1	1	2	2	
Egg	-	1	1	1	1	1	1	
Zwiebach or toast	1	1	2	3	3	3	4	
Butter	-	1	1	2	3	3	4	
Summary	4	6	7	9	11	12	14	
Milk	1	1	1	1	1	1	1	
Zwiebach	1	1	1	1	1	1	1	
Butter	1	1	1	1	1	1	1	
Summary	3	3	3	3	3	3	3	
Chicken or Chop	-	1	1	1	2	2	2	
Potatoes	1	1	1	2	2	3	3	
Vegetable	1	1	1	1	2	2	2	
Pudding	-	-	1	1	1	2	2	
White Bread or Toast	1	1	2	2	2	2	2	
Butter	1	1	1	1	1	1	1	
Milk	-	-	1	1	1	1	2	
Ice Cream	-	1	2	2	2	3	4	
Summary	4	6	8	9	11	13	14	
Milk	1	1	2	2	2	2	3	
Cocoa sugar	1	1	1	1	1	1	2	
Egg	-	-	1	1	1	1	1	
Toast	1	1	1	2	2	3	3	
Butter	-	1	1	2	2	3	3	
Fruit or Vegetable	1	1	1	1	2	2	2	
Summary	4	5	7	9	10	12	14	

Exchangeable one against the other.

CHART II

If we would have:

- 2 children with 24 hour food requirement of 15 portions
- 3 children with 24 hour food requirement of 20 portions
- 8 children with 24 hour food requirement of 25 portions
- 4 children with 24 hour food requirement of 30 portions
- 3 children with 24 hour food requirements of 35 portions

The prescription for our dietetic kitchen would be for luncheon at noon:

Requirement

- for 24 hours. .... 15 20 25 30 35 Summary portions
- Chicken or chop. .... 3 8 4 6 = 21 chicken or chops
- Potatoes ..... 2 3 8 8 6 = 27 potatoes
- Vegetable (\*) .... 2 3 8 4 6 = 23 vegetables
- Pudding (\*) ..... 8 4 3 = 15 pudding
- White bread ..... 2 3 16 8 6 = 36 white bread
- Butter ..... 2 3 8 8 3 = 20 butter

The prescriptions in the kitchen are calculated for ten portions: To get ten portions of potatoes (1,000 nem — 10 hektionem = 667 calories, we use the following prescription:

- Potato ..... 400 gms. = 5 hn.
- Butter ..... 34 gms. = 4 hn.
- Milk ..... 100 gms. = 1 hn.

Final volume ..... 500 ccm. = 10 hn.

For vegetables the same nutritive value (10 portions — 10 hektionem — 667 cal.)

- Green peas ..... 500 gms. = 5 hn.
- Butter ..... 34 gms. = 4 hn.

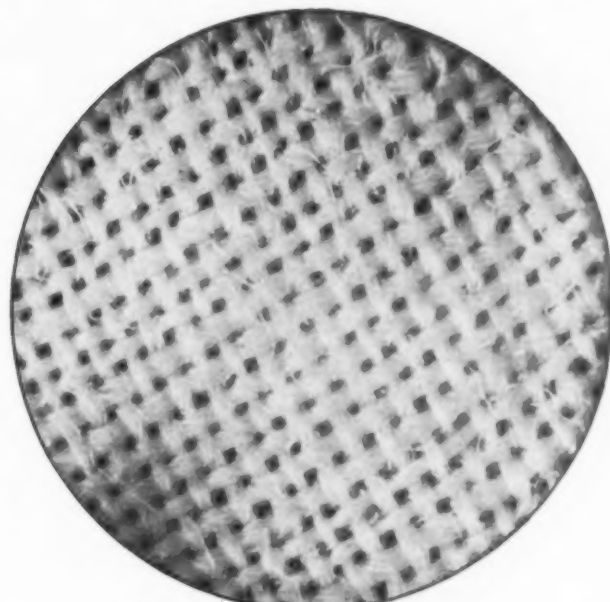
\*The choice of the vegetables and puddings is left to the supervisor of the kitchen. She knows which are desirable and which are not permitted.

\*Philadelphia and London, W. B. Saunders Company, 1922.

# Science in Your Laundry



Harsh Cleansers Produced This Result  
(Notice the frayed condition of the threads)



Sheeting Washed with ESCOLITE  
(Fabric unharmed, light, fluffy)

## Washes Clean, Sterile Yet Harmless to Fabrics

### One of Many Remarkable Tests

Operators of hospital laundries who depend on ordinary laundry preparations will be interested in the results of the text illustrated above.

Two pieces of cotton sheeting exactly alike were washed under the same conditions, in soft water at the same temperature, 160°. Two hot rinses followed each bath, but no ironing, scouring, bleaching, or bluing. The washing operation was performed twenty times in order to show the results of repeated washings. The first piece was washed in a bath containing a well-known alkaline cleanser (no soap), the second in one containing an equal amount of Escolite. Both pieces, exactly as they appeared after washing but magnified fifty diameters, are shown above. To the eye alone both pieces look the same—the microscope tells the story.

The first illustrates the effect of free alkali on the threads of the cloth. They are disarranged, broken, unraveled, left with loose ends, producing lint and eventually holes. The fabric washed with Escolite is absolutely sound and well preserved, the texture light and fluffy. Linens, uniforms and blankets washed with Escolite are assured of long life, clear, spotless whiteness and of being the cause of gratification on the part of the hospital executives.

THE BALANCED MINERAL DETERGENT

# ESCOLITE

PATENTED JUNE 13, 1922

Colloidal alkali, the foundation of Escolite the scientific detergent, is derived from a pure mineral base. It washes by controlled, thorough, penetrating deterative activity without caustics, excessive bleach or injury to fabrics. It produces a snowy whiteness which quality is accompanied by sterilizing properties.

A COWLES SERVICE MAN will gladly visit your laundry, demonstrate Escolite and make you many valuable suggestions as to scientific laundry methods. This service will be given without obligation on your part except to make a fair test.

### Free, Valuable Manuals

"Science in Your Washroom" a 22-page booklet containing the principles which underlie all successful laundry practices, can be used with advantage almost every day. Put it on your desk for frequent study and reference.

"Tell-U-How" Talks—a series of scientific treatises on proved modern methods will be sent you as issued Free at your request. Use the coupon below.

### THE COWLES DETERGENT CO.

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- ☐ Send Cowles Service Man without obligation to me.
- ☐ Please put my name on the list to receive copies of "Tell-U-How" Talks.
- ☐ Send copy of 22-page bulletin "Science in Your Washroom."

Name .....  
Street .....  
City ..... State .....

Sugar ..... 17 gms. = 1 hn.  
 Final volume ..... 500 cc. = 1 hn.

Distribution is done by graduated dippers containing fifty or 150 ccm. Bread, chicken, butter, etc., must be weighed.

The diet kitchen has to prepare only the required amount actually needed in number of portions ordered, and in so doing there is none or almost no waste. As each child gets his food according to his requirement, we can eventually force him to eat this amount of food, since we know that it is not too much for him. Formerly, the nurse did not force the child to eat his meal because she was not sure whether or not the child should eat as much as she served. Purposely forced feeding also helps to avoid waste.

For children with severe acute symptoms and fever we calculate as the required nutritive value at least the "minimum" covering the requirement for basal metabolism, and select for this purpose the usual foodstuffs, milk, sugar (with fruit juice or tea) eventually egg and zwi-bach. The preparation of these foodstuffs can be done by the nurse.

In doing so we are confident that we know what we do, we know how much nutritive value should be given to the child and we can control the amount, therefore we know he is getting his requirement. The subjective dosage after feeding is substituted by objective dosage. Besides this, I believe that in prescribing the amount of caloric value actually needed, the physician and nurse achieve a systematic education in the feeding of children.

The introduction of a new system always appears, at the beginning, a little complicated, because it means change of accustomed procedure, and therefore entails a little more work and thought. But if the new rules are

well-founded and established, this new method becomes more routine, later the new method becomes an old one and may have to be changed for another new method.

One person alone cannot organize a new system of nutrition. A whole-hearted cooperation of the entire staff, dietitians, nurses and physicians, is needed. I was fortunate enough to find this in my department here at Mount Sinai. I have no doubt that all children's departments need to organize the feeding of their children above infancy, not only the feeding of the infants and such organization is needed for the proper treatment of sick children. In Pirquet's system we have a scientific and economical basis for that very important part of medical care—nutrition.

The organization of this department was made possible through the kindness of Mr. George Blumenthal, president of the board of trustees, of Mount Sinai Hospital. The results obtained have been greatly facilitated by the efforts and cooperation of the staff of nurses under the supervision of Miss Ball, head nurse in children's pavilion, and the dietitians in the diet kitchen under the supervision of Miss Graves.

#### DIET LISTS RECOMMENDED BY SOUTHERN CALIFORNIA DIETETIC ASSOCIATION

The following house diet lists have been compiled by the doctors and dietitians, and are recommended by the Southern California Dietetic Association. The committee of doctors and dietitians have agreed upon standard diets and put them into practice, successfully in the general hospitals at Inglewood, Cal., and vicinity.

(For News Items see page 506)

Type of Food	Restricted Liquid Diet	Liquid Diet	Soft Diet	Light Diet	**Full Diet
Cereals	Cereal Water	Gruels (well strained)	*Cereals (well cooked) Italian pastes, as spaghetti (plain cooked) White bread (not fresh) Soda crackers	Soft diet plus prepared cereals; graham bread	Same as on light diet
Vegetables and potatoes			Pureed vegetables Baked potatoes Mashed potatoes	Vegetables (young and not coarse) Potatoes	Light diet plus coarse vegetables
Fruits	Fruit juices (well strained)	Fruit juices (well strained)	Liquid diet plus cooked fruits (without seeds, coarse skins or heavy fiber)	Soft diet plus All cooked fruits Citrus fruits	All fruits
Desserts	Ices Jello	Ices Ice cream Jello Junket	Liquid diet plus simple desserts Milk puddings Custards Gelatine desserts Sponge cake Angel food cake	Soft diet plus Simple puddings Simple cakes	Same as on light diet
Milk Cheese Eggs Meat Nuts	Albumins	Milk Cream Malted milks Buttermilk Bulgarian Milks Cocoa Chocolate Egg nog Albumins	Liquid diet plus eggs (soft cooked) Cottage cheese Butter	Soft diet plus Cheese (creamed or grated) Eggs Poultry Fish Sweetbreads Brains Scraped beef Broiled bacon Broiled lamb chops	Light diet plus Steaks Roasts Ground meats
Soups, etc.	Clear broth Beef tea Strained soups (without milk)	Clear broth Beef tea Soups (well strained)	Same as on liquid diet	All soups as served by the house.	All soups as served by the house
Miscellaneous	Tea Coffee Postum, etc.	Tea Coffee Postum, etc.	Same as on liquid diet	Liquid diet plus Olives Mayonnaise	Same as on liquid diet

\* Except cereals containing bran.

\*\* Bran breads and cereals, fresh pork, fried foods, highly seasoned foods, and pastries are never served to general patients except by special order from the doctor in charge.

HEADQUARTERS FOR THE ORGANO THERAPEUTIC AGENTS

# Make the Milk Digestible

with chymogen which precipitates the casein in soft flocculent particles and prevents the formation of large curd.

Chymogenized milk is unchanged in taste and value. It is the food for infants and invalids.

## CHYMOGEN

is a combination of enzymes and care must be taken to prevent overheating—105 degrees F. is the proper temperature.

**Boil milk;** let cool to 105 degrees F.; add Chymogen and stir thoroughly.

### PITUITARY LIQUID

the premier product of Posterior Pituitary. Surgical 1 c.c. ampoules, Obstetrical ½ c.c. ampoules.

*Literature for Hospitals and Physicians*

### ARMOUR'S CATGUT LIGATURES

non-boilable, plain and chromic, 000 to 4 inclusive, flexible, strong and sterile; also boilable ligatures.

### PARATHYROID

Powder 1-10 and 1-20 grain tablets.



**ARMOUR AND COMPANY — CHICAGO**

## FIRE PREVENTION DEPARTMENT

Conducted by W. M. Krieger, Engineer,  
209 West Jackson Boulevard, Chicago, Ill.

### SUGGESTIONS FOR IMPROVING STRUCTURAL DEFECTS IN HOSPITAL BUILDINGS

**M**ANY hospital buildings are of highly combustible construction and present large areas with absolutely no provision for checking the spread of smoke and fire, which can communicate between floors by means of open stairways, elevator shafts, dumb waiters, clothes and rubbish chutes and various other openings. The ordinary wood joisted hospital building is a potential furnace, with masses of wood, dry as tinder, enclosed in oven-like walls. The speed with which fire spreads in such a building is often appalling. The spaces between the studding in the partition walls is often unstoppered from the basement to the attic, and a few minutes after a basement fire gets under way the attic is a mass of flames and the building doomed. Brick or stone walls add practically nothing to the safety of a building with a wooden interior.

New hospital buildings should be of a fire-resistive construction throughout. Buildings should be separated by standard fire walls or by at least fifty feet of open space. All floors of adjoining buildings should be connected only by fire-resistive corridors with standard automatic closing fire doors on the openings or by openings through fire walls protected by automatic closing fire wall doors. In rural communities the general use of one and two story buildings is quite feasible, but in larger cities where land is scarce it is necessary to build higher. Every effort, however, should be made to place the absolutely helpless as close to the ground as possible.

#### Improving Existing Buildings

It is a common fallacy to assume that because a building has brick or stone walls it is relatively safe. Over 75 per cent of our hospital buildings are of frame or wood joisted construction. The need, therefore, is for im-

mediate action toward the improvement of these buildings. An intelligent examination of even a limited number of hospital buildings will convince the most skeptical of the present danger.

One four-story wood joisted buildings was found filled with helpless sick. The only protection provided was inside standpipe and hose and the water pressure was insufficient to reach the upper floors. A paint shop was located in the basement and rubbish chutes from the

basement communicated with upper floors. Another four-story brick wood joisted hospital was found completely filled with bed-ridden patients. Two open stairways led from basement to top floor. All woodwork was old, dry and heavily varnished. The only men found on the property were the engineer and visiting doctor. The hospital was managed solely by women, many of whom were physically feeble. In case of a serious fire on the upper floors, a large loss of life was a foregone conclusion.

The only remedies for such conditions are radical structural changes, or the installation of automatic sprinklers, or a combina-

tion of both. It is criminal to place all dependence upon a few chemical extinguishers or fire escapes.

The following type of structural improvements are of value in combustible buildings: (a) Subdivision of buildings by means of standard fire walls or partitions; (b) Enclose all floorway openings such as stairways, elevator shafts, dumb waiters, rubbish and clothes chutes, etc., with fire-resistive partitions and doors; (c) construction of fire-resistive floor, walls and ceiling about heating apparatus; (d) Protection of entire basement ceiling by metal lath and plaster. This gives considerable protection against fire; sheet metal nailed to joist does not; (e) Elimination of wooden shingle roofs.

#### Gratis Inspection Service

**T**HE fire protection engineers of this department will gladly look over preliminary plans without cost and will make suggestions and furnish other information relative to insurance costs, safety from fire, or danger of life, and will freely give their general experiences relating to any particular new work to be undertaken. We shall gladly make a survey of your property and determine your needs along these lines.

*General Motors Building —  
Detroit*



*The Cafeteria —  
Seats 1000 persons*

## A Service for All Who Serve the Public

The General Motors Building at Detroit, is the largest office building in the world. Thousands of people work within its walls. Thousands of them eat daily in the cafeteria and restaurant operated in connection with it.

John Sexton & Company filled the opening order in the cafeteria and restaurant of this mammoth building, and Sexton foods have been served regularly ever since. It is a great source of satisfaction to thus serve the busy workers in this great business establishment. It is a reliable indication of the scope of the service rendered by the nation's largest distributor of No. 10 quality canned foods.

Whether large or small, whether you operate a one-story restaurant or a large hotel cafe, a hos-

pital or some other institution, if you use canned fruits and vegetables, teas and coffees, in quantity, you will profit by using Sexton Service. Your duty to the public demands that a high standard of excellence be maintained. In the various Sexton grades you will find just what you need to please your patrons and yet make worth-while savings. In every instance, every Sexton product is packed in the container most serviceable and most economical for the institutional user.

Any way in which we can serve you will be welcomed, whether it be to send you our latest bulletin, to have our representative call to confer with you, or to send you samples of some of our varied line of products. Please feel free to call upon us.

# JOHN SEXTON & CO.

**WHOLESALE GROCERS Chicago**

EDELWEISS  
FOOD PRODUCTS  
CHICAGO



AMERICA'S LARGEST  
DISTRIBUTORS OF  
No. 10 CANNED FOODS

*Specializing only in the supply of Hotels, Restaurants, Institutions,  
Clubs and Railroad Dining Systems*

Fire walls prevent the spread of fire horizontally, and to confine fires as much as possible, every advantage should be taken of existing walls to make them effective fire stops. Unnecessary openings can be bricked up, walls can be carried through the attic and roof, timbers which originally passed through walls can be cut off so as not to create continuous combustible channels through the walls and necessary fire wall doors can be provided.

There are standard fire doors of many kinds designed to conform to all conditions. Fire doors sliding vertically or horizontally, swinging doors, rolling steel doors are available to meet varying conditions. Wood tinclad doors are in common use for protecting large openings in important fire walls. Solid steel doors are also used for this purpose as well as for smaller openings. Sheet metal and hollow metal doors of various patented forms are also available. Rolling steel doors are available for openings where lack of space prohibits the use of doors of other types. Doors can be furnished, which are highly finished to imitate woodwork. While ornamental, they are capable of furnishing the required degree of fire protection.

All fire doors should be made to close automatically by use of fusible links or other heat operated devices. A fire door which does not close automatically is never certain of being in the closed position in case of fire. Fire doors which have been built correctly and which come up to certain standard requirements will bear the mark of approval of the Underwriters Laboratories.

In some combustible hospital buildings of large area the only proper treatment is to build one or more effective fire walls across the building. Some of the large public and private hospitals in the country are hundreds of feet long, the equivalent of five or six story levels in height, and literally without any sign of a fire stop either horizontally or vertically. Such conditions in a factory or mercantile property would be considered little short of an economic crime, and it is certainly quite as desirable that the same steps which would be taken in a business building should be taken in a hospital building housing hundreds of persons, many of whom are helpless.

#### Stairway and Elevator Shafts

Fire usually spreads much faster vertically than horizontally and for that reason it is most important that it have no open path from the room or floor in which it starts to rooms or floors above, and that there be no openings in the floor through which burning embers may drop, spreading the fire in the story below. Such openings permit the rapid destruction of a building by a fire and their protection is imperative to safeguard both the building and the lives of its occupants.

Stairways should be enclosed in strong partitions, preferably of incombustible material with self closing fire doors but good double boarded partitions and doors are suitable for many conditions. The enclosures should be liberal in size, well-lighted both with outside windows and artificially, with wide hallways to permit occupants of upper stories to pass out while being protected from a fire which may be in a lower story.

Doors should swing outward from the rooms and be located near the top of the stairs so that occupants passing down the stairs will not tend to close the door against those coming from the rooms, and so that the latter will not crowd those at the foot of the stairs. Doors should be made self-closing by means of weights hung on chains or by strong springs. There should be no locks on the doors.

Elevators should be enclosed in wells built as described for stairways; or automatic traps, which open and close

as the elevator passes, may be used. The structure should be solidly built of brick, concrete, terra cotta, or wire lath and cement plaster according to the conditions and best means available. Openings into the elevator enclosures on each floor should be guarded by approved self-closing fire doors. Care should be taken to close off the tops of all elevator wells. They should never have unprotected openings into attics or hollow roofs. Preferably the roof over elevators should be raised, the well being extended above the main roof. Windows or skylights should be put in the extensions above the main roof to ventilate the shaft and serve as a heat and smoke vent. Thin glass protected on the outside with screens should be used.

Dumbwaiters should be enclosed, as are elevators, their entire length with vertical sliding doors made to close automatically with fusible links.

#### Attics with Steep Roofs

Steep roofs forming attics or other places above the upper story ceiling in a building, always present defects so far as fire is concerned. Where extensive, these attics should be frequently stopped off by good tight partitions at least equivalent to double boards with lapped joints extending from the floor to the roof. It is especially important that such partitions be located to separate wings or extensions so that a fire may be confined for a time to make it possible to concentrate hose streams on the portion of the building where the fire starts. This suggestion would apply also to all roof spaces even if very low, where the fire could pass over the tops of the joists.

#### Skylights Should Have Wired Glass

Skylights of plain glass with wooden sash should be replaced with wired glass in metal sash and frames. Where the exposures are not severe, plain glass skylights may be permitted, if protected by galvanized iron screens supported on a metal frame six inches above the glass and extending six inches beyond the skylights on all sides. The screens should be made of wire not smaller than twelve gauge and have meshes not larger than one inch. Vertical windows in monitors should also be protected by screens, but they may be fastened directly to the outer walls.

Over the tops of elevator wells, light wells, dumb waiters, stairways, etc., no wired glass should be used. Plain glass properly screened is preferred, as it will break in case of a severe internal fire and serve to vent the building.

#### Shingle Roofs Objectionable

The biggest factor in preventing an exposure fire from effecting hospital buildings is to eliminate wooden shingle or other combustible roofing. Shingle roofs are objectionable also because sparks or brands from chimneys of the building itself may set fire to the roof. No exposing shingle roof should be permitted to be repaired extensively with wooden shingles. Various approved forms of fire-resistive roofing materials, weighing about the same as wood shingles, may be installed without appreciable difference in cost. Any kind of a roof is safer than a wooden shingle roof. Other roofs may burn, but they will not ignite from sparks, and will not furnish flying brands. The wooden shingle is a notorious conflagration breeder. It furnishes both the fire brand and the tinder which it ignites.

#### Heating and Ventilating Systems

Heating boilers should almost without exception be located in the basement.

(Continued on page 506)



5 FT. OF LONG FIBER. PURE, GINNED COTTON

## EASE YOUR PATIENT ON THE *Sealy* AND YOUR HOSPITAL BECOMES A GRATEFUL MEMORY



**T**O the average convalescing patient,—comfort and rest mean more than medicine,—or any other scientific treatment of modern times.—This is based on the opinions of the foremost physicians of the world, and means in short, that the mattress is the most important unit in the hospital room.

The Sealy has no substitute or "just as good."

The Sealy yields gently to every curve and position of the body,—supporting and relaxing each tired muscle.—The refreshing rest that results from a night spent on a Sealy, tends in a great measure to ease the suffering of patients, and to alleviate the feeling of discontentment, usually prevalent among them.

The Sealy is built to withstand heavy usage for countless years without sacrificing its softness, buoyancy or original shape,—and the only renovation required, is an occasional sun bath,—which in itself, is an unusual economy of upkeep.

Please write your nearest manufacturer for descriptive catalog

**The Sealy Mattress Company**

### There's a Factory Near You

Sugarland, Texas  
Memphis, Tenn.  
New York, N. Y.  
Pittsburgh, Pa.  
Cleveland, Ohio  
Detroit, Mich.  
St. Paul, Minn.  
Mebane, N. C.  
Richmond, Va.  
Kansas City, Mo.  
Oklahoma City, Okla.  
Denver, Colo.  
Houston, Texas  
Los Angeles, Calif.  
San Francisco, Calif.  
Tigard, Ore.  
Indianapolis, Ind.  
St. Louis, Mo.  
Chicago, Ill.  
Salt Lake City, Utah  
San Antonio, Texas  
Baltimore, Md.

## HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by HERMAN SMITH, M.D., Superintendent  
Michael Reese Hospital, Chicago, Ill.

# ELECTRIC HEATING AND COOKING FOR THE HOSPITAL

By A. H. MAUGER, EXECUTIVE DEPARTMENT, EDISON ELECTRIC APPLIANCE CO., SCHENECTADY, N. Y.

**E**LECTRIC heating and cooking for the hospital may be grouped under seven headings, as follows: (1) for the ward and patient, (2) the operating room, (3) the laundry, (4) the laboratory, (5) the diet kitchen, (6) the main kitchen and bakery, (7) for the dietitian's kitchen. The first four involve electric *heating* and the last three electric *cooking* operations.

The general advantages are cleanliness, convenience, absence of flame, fume or combustion, and control of volume and temperature of heat. There is another *control* of the heat in many cases; that is, you can have the heat where you want it. This might be called effectiveness of application. This again makes for convenience, compactness, efficiency and often portability of equipment. Because of their outstanding superiority, such electrical heating appliances as are described below are rapidly replacing older methods and equipment. Most of the smaller appliances may be connected directly to an electric light socket, while a few of the larger heaters and sterilizers require heavier wiring. In most cases the advantages are obvious.

### For the Ward and Patient

The heating pad is flexible, light with continuous, adjustable controlled and maintained heat and is supplied for both dry and wet applications. It is rapidly superseding the inconvenient hot water bottle. It is also supplied in blanket size for special requirements.

The small immersion heater is very convenient for hot drinks and liquid medications.

Radiant heaters have both therapeutic and non-therapeutic use. 1. For therapeutic use there are the small hand sizes, as well as floor standards, for local applications of radiant heat to the body. There are also large portable heaters, or bakers, sometimes called "light" canopies, to be placed over the body in bed for increasing elimination; so-called light bath cabinets in which the patient may sit or lie, for the treatment of nervous disease and other diseases such as rheumatism, requiring increased elimination. Other forms of electric heat therapy such as diathermy may best be discussed under the general subject of physiotherapy. For non-therapeutic uses there are the flood type. These heaters are very convenient, portable, producing quick results. They are supplementary to the regular heating system of the building, not

only in the wards and private rooms, but also in the office.

### For the Operating Room

Electric *steam* sterilizers of various sizes for sterilizing instruments and dressings now often form the equipment of a modern operating room. Because of the importance of sterilization no pains are spared to secure the most satisfactory, convenient and efficient form of sterilizing. *Dry* sterilizers are also used for sterilizing dressings, etc. They are forms of the electric oven. The temperature of electric sterilizers can be very nicely controlled and the air of the operating room is not vitiated by burning fuel. Water sterilizers can also be supplied electrically for furnishing sterilized water for the operating room.

The electric cauterizers form of electric heater is much appreciated by surgeons and some of the finest and most delicate instruments are made available by electric heating, which has promoted a great improvement in cautery technique. Electric cauterizers are supplied in sizes from those using a fine platinum wire, flat knife blades, to larger ones resembling the electric soldering iron, and are used in connection with the regulating transformers. In the department of physiotherapy the electric current is applied directly through the patient for ordinary or surgical diathermy in connection with high frequency electric apparatus. Radiant heaters and heating pads similar to those for the wards are used in the operating room.

### For the Laundry

There is a certain amount of work in the laundry which cannot be put through the mangle and which requires the use of a flatiron. The electric flatiron has come into such general use that practically every institutional laundry is equipped with them. They are made in various sizes from six pounds to twenty-five pounds. The result of their use has been a decided increase in the output of the laundress as well as in the higher quality of work. It is estimated that each electric iron saves the laundress two miles per day of walking from the ironing board to the stove. Laundry managers should keep abreast of the refinements in the electric iron which are being made from time to time. Irons should be installed with the latest approved ironing board, wiring and cord support, for the best results.

# Petrolagar

TRADE-MARK

## A WARNING AGAINST IMITATIONS



Imitations flock in the wake of success. It has been brought to our notice that the success of PETROLAGAR has developed some imitators, several packed similar to our product.

None of these imitators has, however, succeeded in producing a product which equals PETROLAGAR in therapeutic action or taste.

The process by which the mineral oil is diffused with the agar-agar in PETROLAGAR was developed after a great deal of research and experiment. It results in the palatable, non-irritating emulsion which gives full lubrication; which gives a bland, gelatinous bulk in the intestine; which has the appearance and taste of pudding sauce.

PETROLAGAR has won its way to a pre-eminent position in its particular field by performance on clinical test.

It has been accepted by the Council on Pharmacy of the American Medical Association for New and Non-Official Remedies.

It is prescribed by leading physicians in every section of the country for the treatment of constipation.

It is stocked by the prescription pharmacy.

Complete formula on every package.

Sold in strict conformance with ethical medical procedure, by a house which **does not** advertise any article to the public.

PETROLAGAR is issued as follows: PETROLAGAR (Plain); PETROLAGAR (With Phenolphthalein); PETROLAGAR (Alkaline) and PETROLAGAR Unsweetened (no sugar).

*Use this coupon to secure a clinical trial specimen.*

### DESHELL LABORATORIES, INC.

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Mail to the Nearest Address

Deshell Laboratories, Inc., Dept. M.H.,  
Gentlemen:

Please send us a clinical specimen of

.....PETROLAGAR (Plain)  
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(mark type desired)

Dr. ....

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Some hospitals have laboratories for various kinds of pathological and pharmaceutical work. A few special electric heating appliances are bacteriological incubators made in various sizes, hotplates for general laboratory use, electric water stills for producing distilled water for testing purposes, steam and hot air sterilizers for sterilizing instruments and water sterilizers for sterilizing water.

### Electric Cooking Applications

The advantages of electric cooking need special emphasis and discussion in detail. In a pamphlet on "Improvement in the Modern Hospital during the last 30 years," Schmidt, in 1918, said "Efficiency in operation for the patient's benefit has been continually improved by more thought being given to providing food in a more attractive and palatable condition due to better and quicker delivery from the kitchen to the bedside. Electricity has greatly helped in this respect."

Schmidt had in mind electric automatic machinery such as push button dumb-waiters, etc. Electricity is now undertaking the heating for cooking operations. The question naturally arises as to the supply of electricity, in such large amounts as are required for cooking and baking. If the hospital is near an electric central station the problem is simple, as an attractive rate can be made for this class of service, because of the desirable character of the load for the central station. However, some hospitals have their own electric generating plant and, doubtless, the capacity would have to be increased to take care of the main cooking. The following advantages will show that electric service is more than justified.

The advantages of electric cooking and baking equipment are vital to the highest type of hospital service—particularly for diet kitchen use. Original diet kitchen installations have proved very effective in securing complete installations in the main kitchen. The foremost hospitals in America have solved their cooking problems in this way.

Good food, wholesome, tasty and nourishing, is essential in hospitals—and electric cooking equipment helps to assure it. The even dependable heat, perfectly controlled by three heat switches gives a sureness of results. The air-tight construction of electric ovens does not dry out the richness of moisture of foods and retains the full natural juices of meats and vegetables, making them much more palatable and nourishing. Baked products do not have the shrinkage that is always caused by fuel type ovens. Breads and pastries retain their freshness longer because the moisture is not dried out in baking. The positive control minimizes the spoilage. The saving of food accomplished by electric cooking and baking equipment produces a considerable balance on the credit side of the hospital ledger.

For cleanliness, nothing surpasses electric heat. The dirt from handling fuel and ashes is entirely eliminated. No soot nor smoke is created. Utensils are not stained and discolored. The work of keeping the kitchen and equipment clean and spotless is greatly simplified.

The presence of noxious fumes cannot be tolerated in a well regulated hospital. Their presence means unhealthy conditions and frequently is very dangerous. Not only are fumes entirely overcome by electric equipment, but disagreeable kitchen cooking odors are prevented. The electricity equipped kitchen does not require much of an investment in ventilating equipment. Kitchen work is reduced. There is no carrying of fuel and ashes; nor is it necessary to worry about fuel supply. Electric heat

is always ready at the turn of a switch. A minimum of attendance is required.

The flexible control of electric equipment permits all the different kinds of food, each requiring a special cooking temperature, to be prepared at the same time. Each section of the various units of equipment is governed by its control which is accurate and positive at all times.

### Reduces Fire Hazard

Electric equipment greatly reduces fire hazard—a vital factor in hospitals. Insurance rates are correspondingly lower.

Patients do not need to be annoyed and disturbed by the noise of building early morning fires. Chopping kindling, sawing and splitting wood, shoveling coal, handling ashes are all noisy tasks which seriously upset patients and hamper their improvement.

The volume of food preparation in hospitals is very large almost equalling that of hotels. Consequently, the better results, greater sanitation, and increased efficiency and economy obtained by electric cooking and baking equipment is important.

The advantages of electric cooking and baking may be summarized as follows: food saving, coolness, cleanliness, flexible control, improved working conditions, saving in floor space, freedom from odors, other advantages such as reduced fire hazards, lower insurance rates, uniform fuel always available.

### For Ward Service or Diet Kitchen

The ward diet or service kitchen is used by the nurses for the preparation of light or special individual meals for the patient. Several nurses use the same diet kitchen. For this reason there should be as much elbow room as possible and the cooking equipment should require as little attention as possible which can be realized with the use of electric equipment.

For the complete preparation of the patients meals the domestic cabinet type of electric range is the most convenient.

Electric hotplates of one, two and three disc are for supplementary use to the electric range. Their use extends the available cooking surface and makes it convenient for several nurses to work at one time in the diet kitchen. In a small kitchen they can be used in place of the electric range, supplemented by the portable electric oven.

When it is convenient to have an additional oven, the portable electric oven may be used in connection with the hotplates instead of the electric range.

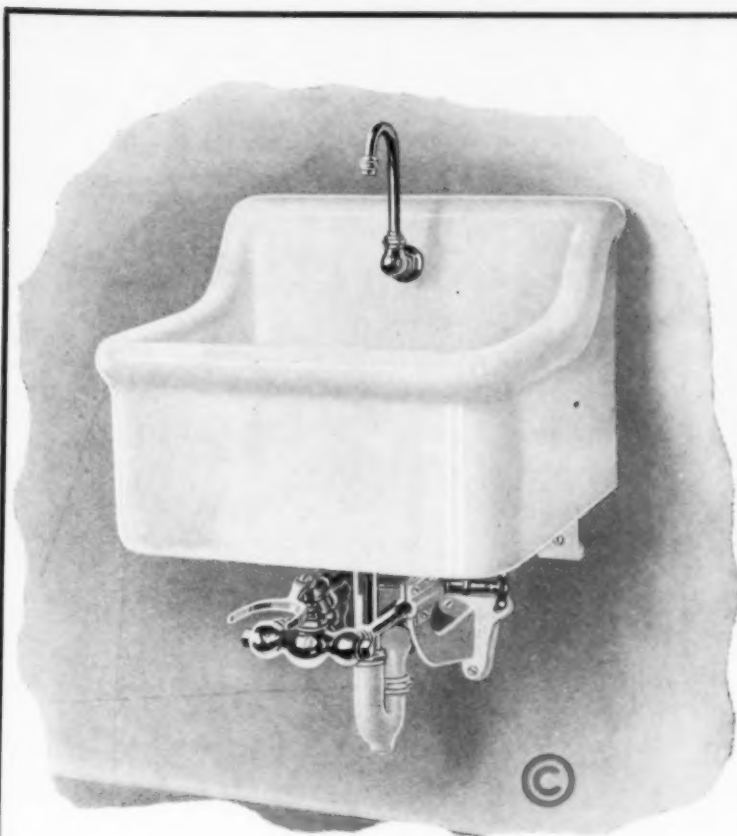
Since toast is one of the principal items of food prepared in the diet kitchen one or two electric toasters should be installed, and in the larger kitchen the six slice toaster may be used.

Within the limited capacity of the electric table grill all the forms of electric cooking may be done, except baking.

### Main Kitchen and Bakery

Electric ranges are very superior to the coal or gas range and may be furnished as complete sectional cooking units or with the hotplate cooking surface only (which is more convenient when there is a separate roasting cook). The amount of cooking surface in active use is under more complete control in the electric range than in the older forms, which makes for efficiency. The advantages have already been noted.

The six and sixteen slice electric toasters supply a quantity of toast with a minimum of spoilage. Electric

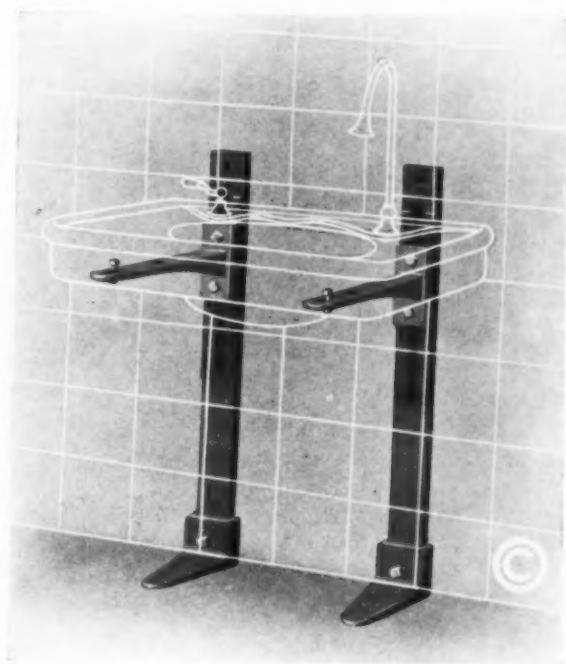


## A New Clow Product of Superior Design

**T**HIS Surgeon's Scrub Sink (22" x 26" x 10" deep), with 6" integrant back, has been designed with a thorough understanding of surgical and hospital requirements.

It has knee-operating mixing valve with wall supports, and goose-neck supply spout. Besides valves for regulation of flow and shut-off, there is a valve regulating volume.

The sink is supported on the Clow Adjustable Floor Stand Hanger (shown here) which allows of convenient height, saves space, and makes for neatness and cleanliness.



**JAMES B. CLOW & SONS**

GENERAL OFFICE

534 SOUTH FRANKLIN STREET, CHICAGO

*Sales Offices in the Principal Cities*

# CLOW

When using advertisements see Classified Index, also refer to YEAR BOOK.

broilers may be supplied in various sizes. Coffee urns can be provided electrically heated where high temperature steam is not available to operate the urn.

Where there is a separate roasting cook, the roasting oven separate from the electric range is desirable.

Griddles and hotplates may be used supplementary to the regular kitchen equipment. If, for any reason, steam is not available stock kettles and steam tables may be electrically heated. Where steam is available, as in most cases, it is more economical to use steam. Electric heat finds its greatest advantage in high temperature work.

The greatest progress has been made with the electric bake oven where the advantages have been more readily appreciated. Uniform distribution of the heat and the ease of regulations make for the better baked product; and results in uniformity of output, with increased operating efficiency and satisfaction to the bakers. The appearance of the bake shop is greatly improved and the surroundings more sanitary. Electric bake ovens are made in various sizes, from thirty to one hundred and eighty loaf capacity with three or four decks; (some of the larger institutions use built-in brick type ovens of two hundred and forty to six hundred loaf capacity, or they may be obtained in sectional form with single decks to be built up as desired. All kinds of baking can be done in these ovens, the heat of which is under perfect control at all times.

#### For the Central Diet Kitchen

Electric cooking equipment is ideal for diet kitchens for the instruction and study of diet as well as for the special preparation of food for the patients. For the smaller dietitian kitchen one or two domestic electric ranges will serve the purpose. These ranges should have the ovens equipped with the automatic temperature control, if possible.

In the larger dietitian's kitchen where the quantities of food prepared are larger, the hotel range may be installed.

Miscellaneous and various separate items such as hotplates, separate ovens, toasters, grills, etc., as noted under the diet kitchen may be used to supplement the range or to provide individual equipment for student nurses.

#### SUGGESTIONS FOR IMPROVING DEFECTS IN HOSPITAL BUILDING

(Continued from page 500)

cated in a fireproof room, if not in a detached building. The opening into this fireproof boiler room should be protected by an automatic closing fire wall.

Flues and ducts of heating and ventilating systems provide ready means for rapid spread of fire. Especially is this true where housekeeping is not of the best, as dust and lint are apt to collect in such places very rapidly. All flues and ducts should be of metal or other non-combustible material. Foul air ducts should never terminate at the attic floor level, but should be carried through the roof. Ducts, flues, and pipes of heating and ventilating systems should be kept clean at all times and wherever these pass through floors or the fire walls, they should be equipped with automatic dampers which, through the melting of a fusible link and the action of closing weights, will cut off the spread of any fire which occurs in or gets into them.

So widespread is the use of motor ambulances, trucks and pleasure cars at hospital buildings, and so severe are the fire hazards involved, that special attention should be given to provision of safe storage space. Wherever

possible, garages should be isolated from main buildings and should always be of non-combustible construction. Where, as in congested districts of cities, it is necessary that garages adjoin main buildings, they should be of fire-resistant construction throughout, with no direct connection to main buildings. Adjoining buildings should be properly protected against exposure.

#### Outer Wall Openings

In congested city districts or in other cases where the neighboring exposure from other buildings is severe, it is important that the outer wall opening of a building be protected against the entrance of fire from the burning of a neighboring building. For this purpose standard tin-clad, solid steel, sheet metal or rolling steel fire shutters should be used. For the more moderate exposures standard wired glass fire windows with all metal sash may be used. In all cases the device used should be made to work automatically in case of fire by the attachment of fusible fire links.

Our architects plan and contractors build good foundations and erect thereon buildings which will stand up. Usually, even the load-carrying capacity may receive due consideration. Style and architectural beauty are never forgotten, but safety from fire generally receives but scant consideration.

#### CONSULTATION SERVICE ON CLEANING PROBLEMS

The special A. H. A. committee on cleaning had a booth on the exhibition floor and some one of the members of the committee was on duty daily throughout the week. Delegates interested in cleaning problems visited this booth for consultation with the men who have been studying the various phases of cleaning. The committee maintained the following schedule: Monday, care of surgical instruments and rubber goods; Tuesday, cleaning of floors, walls, window screens, rugs, carpets, upholstered furniture, plumbing and metals; Wednesday, terminal disinfection; Thursday, laundry processes; Friday, cleaning of dishes and kitchen utensils.

#### APPROVES OF ADMITTING TUBERCULOUS IN GENERAL HOSPITALS

The following resolution was adopted at the recent annual meeting of the National Tuberculosis Association, held in Atlanta, Georgia: Resolved, That the National Tuberculosis Association reaffirms its belief in the need of admitting cases of pulmonary tuberculosis to general hospitals in order to permit of a more intensive training for the young medical men of the country in this field.

#### DIETETIC NEWS ITEMS

(Continued from page 496)

The monthly meeting of the New York Association of Dietitians was held September 29, 1924, at the Fifth Avenue Hospital, New York, N. Y. About seventy-five dietitians were present. Miss Waterman, American Telephone and Telegraph Company, gave a talk on "Employment Problems and Judging Personnel," as they are worked out by the telephone company. Mrs. Huddleston proposed program suggestions for the coming meetings and Miss Graves replied with advice and suggestions. The coming convention was also discussed. After the meeting was adjourned, through the courtesy of Mrs. O'Dea, a tour of the hospital was made and refreshments were served.

## SUCCESS OUR ONLY SALESMAN

The firm of WARD, WELLS, DRESHMAN & GATES employ no advance agents to sell to hospitals, and other institutions our expert money-raising services. Our business is built upon a continuous series of successful campaigns.

For example, in Elmira, New York, we have conducted five campaigns in the last thirty months and we now have been retained to conduct a campaign for the Arnot-Ogden Hospital at Elmira this fall. Three other organizations in Elmira have asked for our services in money-raising. This is a sample record. We have had similar experience in many American cities.

Your hospital can have the advantage of our unparalleled success in money-raising. To secure our service write us telling us of your needs. We will gladly confer with you and give you sound advice without your incurring any obligation to employ our services.

Below is a list of a few of our hospital campaigns:

	Objective	Secured
Fifth Avenue Hospital, New York City.....	\$2,000,000	\$1,850,000
Post Graduate Hospital, New York City.....	2,000,000	1,600,000
United Hospital, Rochester, N. Y.....	1,300,000	1,395,000
Union Protestant Infirmary, Baltimore, Md.....	750,000	810,000
American Hospital of Paris, France (2 campaigns).....	400,000	660,000
Church Home and Infirmary, Baltimore, Md.....	600,000	450,000
Washington Hospital, Washington, Pa.....	500,000	523,000
Miami Valley Hospital, Dayton, Ohio.....	500,000	515,000
Methodist Hospital, Fort Worth, Texas.....	500,000	502,512
Stanford University Hospital, San Francisco.....	500,000	500,000
Presbyterian Hospital, Denver, Colo.....	500,000	500,000
Maryland General Hospital, Baltimore.....	450,000	483,000
Paterson General Hospital, Paterson, N. J.....	400,000	450,000
Memorial Hospital, Pawtucket, R. I.....	300,000	422,190
Eliza Jennings Home, Cleveland, Ohio.....	300,000	362,056
Children's Hospital, St. Louis, Mo.....	300,000	330,000
Mercy Hospital, Pittsfield, Mass.....	250,000	328,000
University of Maryland Hospital, Baltimore.....	250,000	250,000
St. Mary's Hospital, Rochester, N. Y.....	225,000	344,890
Southside Hospital, Bayshore, Long Island, N. Y.....	200,000	230,000
Toronto Western Hospital, Toronto, Can.....	.....	210,000
White Plains Hospital, White Plains, N. Y.....	200,000	200,000
St. Lawrence Hospital, Lansing, Mich.....	200,000	206,000
Maternity & Children's Hospital, Toledo, Ohio.....	150,000	158,500
Methodist Hospital, Sioux City, Iowa.....	125,000	153,500
Pottsville Hospital, Pottsville, Pa.....	100,000	120,000
Hayswood Hospital, Maysville, Ky.....	100,000	116,800
Saratoga Hospital, Saratoga Springs, N. Y.....	100,000	116,000
Cape Cod Hospital, Hyannis, Mass.....	.....	110,000
Ogdensburg City Hospital and Orphanage, N. Y.....	75,000	123,369
United Helpers Home, Ogdensburg, N. Y.....	75,000	116,000
Dobbs Ferry Hospital, Dobbs Ferry, N. Y.....	75,000	116,019
Vineland Hospital, Vineland, N. J.....	75,000	76,000
Shenandoah Hospital, Shenandoah, Pa.....	70,000	110,000
St. Francis Hospital, Poughkeepsie, N. Y.....	75,000	100,000
St. Francis Hospital, Port Jervis, N. Y.....	75,000	80,000
Newcomb Hospital, Vineland, N. J.....	50,000	60,000

Our Quarterly Bulletin, **FINANCING SOCIAL PROGRESS**, gives further details and will be sent upon request.

**WARD, WELLS, DRESHMAN & GATES**  
 PHILANTHROPIC ORGANIZATION AND FINANCE  
 NEW YORK - METROPOLITAN TOWER - CHICAGO - WRIGLEY BLDG

## NEWS OF THE HOSPITALS AND SANATORIUMS

*The department of "News of the Hospitals and Sanatoriums" is prepared each month just prior to going to press, for the purpose of presenting the latest authentic news regarding hospital construction, changes in personnel, and other matters in which the hospital field is interested. So far as we can ascertain, the sources of our information, while not guaranteed, are reliable.*

### General

**New Superintendents.**—The following new superintendents have recently been announced: Dallas City-County Hospital, Dallas, Texas, Dr. Lane B. Cook; University of Colorado Medical School Hospital, Denver, Colo., Mr. George Norlin; Old City Hospital, Kansas City, Mo., Dr. Thomas C. Unthank; State Hospital No. 3, Nevada, Mo., Dr. Emmett F. Hector; Cushman Veterans' Hospital, Tacoma, Wash., Miss Florence Doyle.

**Hospitals Authorized.**—Pursuant to the instruction of the Secretary of War, June 27, 1922, the organization of general hospital, organized reserves No. 81 (Fifth Avenue Hospital Unit, New York, N. Y.), evacuation hospitals No. 82 (St. Vincent's Hospital Unit, Portland, Ore.) and No. 83 (Good Samaritan Hospital Unit, Portland, Ore.), surgical hospital No. 8 (McKeesport Hospital Unit, McKeesport, Pa.), and general hospital No. 84, (Elizabeth General Hospital, Elizabeth, N. J.) has been authorized.

**Hospital Unit to be Known as General Hospital No. 84.**—Word has been received from Surgeon General Merritte W. Ireland that General Hospital Unit, Elizabeth General Hospital, Elizabeth, N. J., is to be known as General Hospital No. 84, instead of No. 34.

**Hospitals and Additions Recently Opened.**—The following hospitals and additions have recently been opened: New nurses' home for the Druid City Hospital, Tuscaloosa, Ala.; Children's building for the Tulare-Kings County Joint Tuberculous Hospital, Springville, Cal.; first unit of the Neuro-Psychiatric Hospital, Pueblo, Colo.; Clinton Hospital, Clinton, Ind.; new home for the U. S. Veterans' Hospital, Knoxville, Iowa; home for the north Louisiana Sanitarium, Shreveport, La.; New Prague Community Hospital, New Prague, Minn.; addition for the Parker Memorial Hospital, Columbia, Mo.; building for the Odd Fellow's Home of Missouri, Edina, Mo.; Interdenomination Home for Girls, Kansas City, Mo.; wing for the New Hampshire Memorial Hospital, Concord, N. H.; building for the Vassar Brothers' Hospital, Poughkeepsie, N. Y.; new Children's Hospital, Pennsylvania State Sanatorium for Tuberculosis, Mont Alto, Pa.; Mercer Cottage Hospital, Mercer, Pa.; annex for the Pottstown Homeopathic Hospital, Pottstown, Pa.

**Bequests and Donations to Hospitals and Allied Institutions.**—The following bequests and donations to hospitals

have been announced: The Shriners' Hospital for Crippled Children, St. Louis, Mo., the estate of Col. Clarence R. Sinclair, the value of which is estimated at more than \$100,000 for the erection and maintenance of a home for convalescent children; Methodist Episcopal Hospital, Brooklyn, N. Y., \$100,000 from an anonymous donor; The Wisconsin Deaconess Hospital, Green Bay, \$50,000, by Dr. Julius J. Bellin, Green Bay; the Church Home and Infirmary, Baltimore, \$50,000 from Frank P. Woodside, as a memorial to his parents to be used to provide a room for free patients; the City Hospital, Hamburg, Iowa, \$5,000 by the will of Mrs. Mary Shoults; the Staten Island Hospital, \$25,000 by the will of the late William G. Willcox; the Sharon Sanatorium, Boston, Mass., an anonymous gift of \$25,000; the Hospital for Ruptured and Crippled, the Beth Israel Hospital, the Sydenham Hospital, and the Hospital for Joint Diseases, New York, N. Y., \$1,000 each from the will of the late Elkan Naumburg.

### Alabama

**To Superintend Alabama Baptist Hospital.**—The Rev. W. R. Seymour, San Angelo, Texas, has been elected superintendent of the Baptist Hospital, Selma.

### California

**New Sanatorium for Monrovia.**—Dr. Robert T. Williams, Monrovia, will construct a new \$25,000 sanatorium.

**Covina Hospital at Glendora.**—Ground has been broken for a new Covina Hospital at Glendora opposite the city park.

**New Home for St. Vincent's Hospital.**—Plans are being prepared for a new home for St. Vincent's Hospital, Los Angeles.

**Four-story Hospital Opened at La Jolla.**—A new four-story hospital with a capacity of thirty-one private rooms and wards was recently opened at La Jolla.

**Donates Hospital to La Jolla.**—Miss Ellen Browning Scripps, La Jolla, has donated the sum of \$250,000 for the Scripps Memorial Hospital, La Jolla.

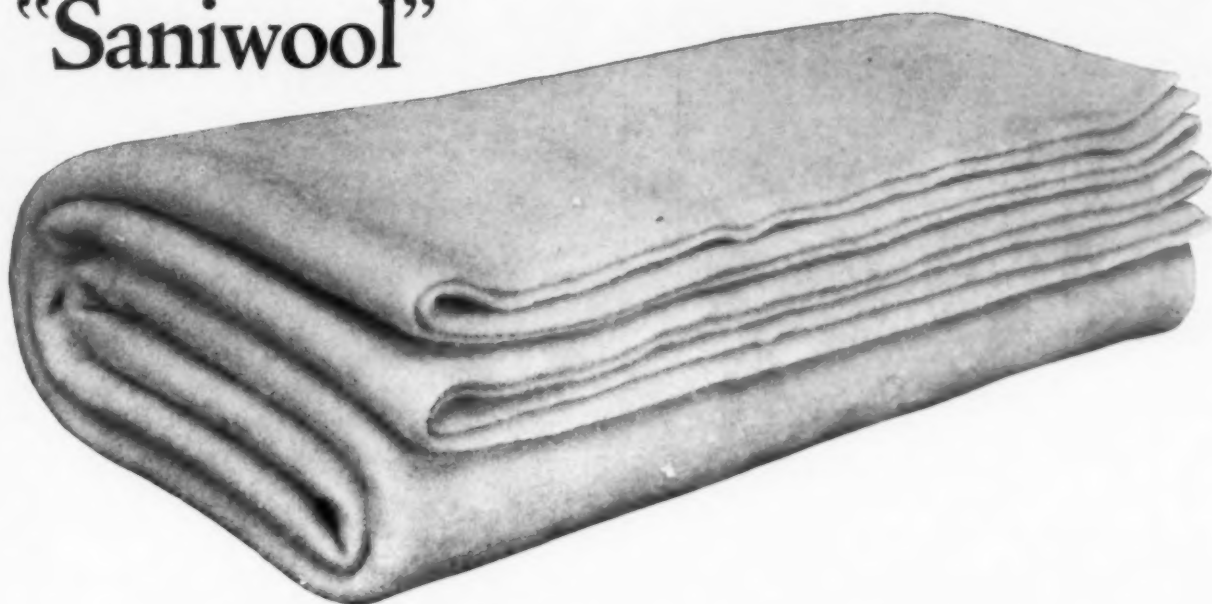
**Hospital Unit for Abdun-Nur Clinic.**—A new building adjoining the Abdun-Nur Clinic, Los Angeles, is being erected to house the hospital unit, the laboratories, x-ray unit and dental department for the clinic.

**Appropriation for Tuberculosis Preventorium.**—The San Francisco supervisors appropriated \$10,000 for preliminary work on a new tuberculosis preventorium which will be built by the city of San Francisco west of Redwood City.

### Colorado

**Canon City Sanitarium.**—Plans are being prepared for the main building of the Sanitarium for Canon City.

## EATON "Saniwool"



### A Blanket Scientifically Built for Long Hospital Wear

**H**ERE is a blanket combining all the time-honored characteristics of EATON quality with the special requirements demanded by hospital usage.

The EATON "Saniwool" is essentially a hospital blanket built upon definite specifications, the direct result of a long series of scientific tests made under actual hospital conditions.

This means, briefly, that many of the country's leading superintendents matched their full co-operation, with our 88 years' experience in blanket manufacturing, to determine scientifically the best average weights, proper

lengths of fibre, and correct range of colors to insure long wear and blanket satisfaction under all hospital conditions.

The EATON "Saniwool" is produced under the most ideal and sanitary manufacturing conditions. This blanket is woven from long fibre wool and withstands long hard usage by delivering many times the wear of a cotton-wool blanket.

Best of all the EATON "Saniwool" is strikingly economical. The first cost is no higher than is asked for the ordinary, and its wearing qualities reduce replacement costs to a minimum.

*Size 60" x 84" and 66" x 84". Weight 4 pounds*

*Colors—Blue Heather, Brown Heather, Natural Gray, and White*

SAMPLE BLANKET SENT UPON REQUEST WITHOUT OBLIGATION

## EATON RAPIDS WOOLEN MILLS

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## Our Barley Boy

# Barley Builds Better Babies!

BARLEY—the food of the gladiators, the fighting ration of the armies of antiquity, Caesar's choice dish, the bone and muscle builder of the ages, the King of grain foods for centuries.

The importance of Barley Water in infant feeding has long been recognized. As a simple, highly beneficial, and easily assimilable nourishment for invalids, Barley is steadily growing in favor among physicians, dietitians, and nurses

JOHNSON'S PURE BARLEY FLOUR, an American product, carefully milled from selected American Barley, provides this valuable food in a form especially adapted to the needs of infants and invalids.

There are many delectable ways of serving JOHNSON'S PURE BARLEY FLOUR to patients—ways which supply appetizing, health-building dishes for young and old.

### FREE TO HOSPITALS

A full-sized can of JOHNSON'S PURE BARLEY FLOUR and also a package of CREAM OF BARLEY, will be sent Hospital superintendents or dietitians free upon request.

### American Barley Sales Corporation

77 West Washington St.  
CHICAGO



#### CREAM OF BARLEY

Carefully milled from the whole Barley grain, served with cream and sugar provides a perfectly balanced, highly nutritive food, especially valuable for growing children, invalids and those suffering from malnutrition.

Served as a breakfast cereal it has a delicious, rich, nutty, fascinating flavor.

**New Infirmary Building for National Jewish Home.**—The National Jewish Hospital for Consumptives, Denver, is planning the erection of a \$300,000 infirmary building within the next year.

### Connecticut

**Break Ground for Nurses' Home.**—Ground was broken September 8 for the Marie Lewis Memorial Home for the nurses of St. Raphaels' Hospital, New Haven. The home will be a four-story modern building.

**To Superintend Bridgeport Hospital.**—Dr. Harold W. Hersey, formerly superintendent New Haven Hospital, New Haven, announces that he has accepted the superintendency of the Bridgeport Hospital, Bridgeport.

### Delaware

**Maternity Addition for Delaware Hospital.**—A new twenty-five bed addition is being completed at the Delaware Hospital, Wilmington.

### District of Columbia

**Nurses' Home for Crittenton Home.**—Bids are being taken for the nurses' home and dormitory for the Crittenton Home, Washington. The building is to be three stories high and will cost \$200,000.

**Dr. Whitmore to be Pathologist at Georgetown University Hospital.**—Dr. Eugene R. Whitmore, professor of bacteriology and preventive medicine in George Washington University Medical School, has been appointed professor of bacteriology and pathology at Georgetown University Hospital, Washington, D. C.

### Florida

**New Hospital for Palatka.**—A new thirty bed hospital is under construction at Palatka.

**Plan South Florida Hospital.**—A new general hospital is being planned for Coral Gables. The children's hospital will be a separate building of about twenty beds.

### Georgia

**Addition to St. Joseph Infirmary.**—Plans have been prepared for a new addition for St. Joseph Infirmary, Atlanta.

**Addition to King's Daughters' Hospitals.**—An addition to cost \$150,000 is being planned for the King's Daughters' Hospital, Waycross.

**Plan Newman Hospital.**—Plans have been prepared and contract awarded for the erection of the Newman Hospital, Newman. The building will be two stories high and of reinforced concrete and hollow tile construction.

**Grady Hospital to Enlarge.**—Plans are now under way for a \$150,000 annex to the Grady Hospital, Atlanta. The new building will be four stories high and will contain wards for the care of patients suffering from contagious diseases.

### Idaho

**To Superintend Hillsboro Hospital.**—Miss Hazel Thompson, a graduate of Lakeside Hospital, Chicago, Ill., has accepted the position of superintendent of the Hillsboro Hospital to succeed Miss Jennie Ware who has been acting superintendent.

### Illinois

**St. Anne's Hospital to Enlarge.**—A new \$250,000 home is being planned for St. Anne's Hospital, Chicago.

**Three Story Hospital for Berwyn.**—A three story and

## Chlorine for Respiratory Infections

THERE is convincing evidence that the chlorine treatment described by Vedder & Sawyer (Journal American Medical Association, Vol. 82, pages 764-766) is effective provided the chlorine concentration is constantly maintained at 0.015 milligrams per liter.

The problem is not to measure the amount of chlorine introduced initially into a room to give the concentration required. The real problem is to maintain the proper concentration to make sure that the patient is receiving the correct amount during the full hour period.

The equipment offered by this company is based upon our experience in developing the apparatus used at Edgewood Arsenal in the original research investigations and meets with the approval of the originators since it insures the administration of the treatment precisely as worked out by them.

WRITE FOR TECHNICAL PUBLICATION NO. 61  
GIVING FULL DETAILS

*Wallace & Tiernan Company, Inc., are manufacturers of Chlorine Control Apparatus. Over 6,000 units of W & T equipment sterilize nearly 80% of the drinking water supplied in North America. Practically every city in the United States has one or more installations of W & T equipment at water works, swimming pools or manufacturing plants. A large staff of experts cover the country.*

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## ECONOMY

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Measure Results Obtained By Money  
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MARY FRANCES KERN CAM-  
PAIGNS never under-estimate the  
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Neither Do They Prolong a Drive to the  
Point of Public Exhaustion—

To find the happy medium is the True  
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To Do This Requires a High Order of  
Executive Ability Plus that Indis-  
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basement general hospital is being planned for Berwyn.

**New Building at Dixon State Hospital.**—A \$200,000 building is being erected at Dixon State Hospital, Dixon.

**St. Francis to Have New Hospital.**—St. Francis Hospital, East St. Louis, is planning a new \$250,000 building.

**Work Discontinued on St. James' Hospital.**—Work has been stopped on the proposed enlargement of St. James Hospital, Chicago Heights.

**Addition for St. Francis' Hospital.**—St. Francis' Hospital, Evanston, has completed a new \$450,000 addition which was opened October 4.

**New Hospital for Illinois Orphans' Home.**—A new \$100,000 hospital and restaurant will be erected at the Illinois Soldiers' Orphans' Home, Normal.

**Nurses' Home for St. Elizabeth's Hospital.**—Bids have been taken for the erection of a \$225,000 nurses' home for St. Elizabeth's Hospital, Chicago.

**Cornerstone Laid for Holden Hospital.**—The cornerstone was recently laid for the Holden Hospital, Carbondale. The building is expected to be completed in November at a cost of \$60,000.

**Mercy Hospital Celebrates Fiftieth Anniversary.**—Mercy Hospital, Chicago, celebrated its fiftieth anniversary, Wednesday, October 22. A solemn pontifical mass was celebrated at 10 a. m. by His Grace, the Most Reverend Michael J. Curley, D.D., archbishop of Baltimore.

**Clinics for Crippled Children.**—Since January 1921, the state department of public health has conducted more than 350 clinics for crippled children at forty-two points throughout the state. A total of 8,228 patients attended the clinics and medical service was given all who were unable to obtain it from private sources. Only ten per cent of the children seen were placed in institutions.

### Indiana

**Plan Hospital for Michigan City.**—A new 175 bed hospital is being planned for Michigan City.

**To Construct a \$50,000 Hospital for Gary.**—Dr. Fred G. McMitchell Gary, will construct a new \$50,000 hospital building to accommodate twenty-five patients.

**Lay Cornerstone for Howard County Hospital.**—The cornerstone of the Howard County Hospital, Kokomo, was recently laid. The hospital will contain fifty-two beds.

**Riley Hospital Week in Indianapolis.**—October 1 to 7 was observed as Riley Hospital week in Indiana. The Riley Hospital for children, Indianapolis, was formerly dedicated October 7, the birthday anniversary of the poet.

### Iowa

**Addition Planned for Polk County Public Hospital.**—A forty-bed addition is being erected at Polk County Public Hospital, Des Moines.

**New Hydrotherapy Building for Clarinda State Hospital.**—A new hydrotherapy building to cost \$125,000 is being planned for the Clarinda State Hospital, Clarinda.

**Purchase Mineral Springs Hospital.**—Drs. P. G. Pomeroy and W. D. Hall have purchased the Mineral Springs Hospital, Marengo, of Drs. William P. Hutchins and F. F. Winsell.

### Kentucky

**Plan New Home for Waverly Hills Sanatorium.**—Plans are being made for the erection of a new \$1,000,000 home for the Waverly Hills Sanatorium, Valley Station.

**To Superintend City Hospital.**—J. Ernest Shouse, who has been assistant superintendent of the City Hospital,



## Health Food *plus* that rich deliciousness that tempts indifferent appetites

Whole grains, crisp and toasty; the enticement of a confection, the flavor of nutmeats—that is Puffed Wheat and Puffed Rice.

Steam exploded to eight times natural size, every food cell is broken to make digestion easy. Children adore them—no adult appetite but delights in the delightful change from ordinary cereals which they offer.

For breakfast, Puffed Rice. At bedtime, Puffed Wheat. At luncheon, either one in a bowl of half and half . . . one of the three may solve a problem for you today.

**Quaker Puffed Wheat**  
**Quaker Puffed Rice**



## VANILLA EXTRACT

1892  
1924

**You Dietitians** are confronted day after day with the never-ending problem of appealing to appetites that are below normal. You know what large dependence you place upon vanilla extract as a flavor that always pleases.

To improve the dietetic value of foods by giving them a perfect and appealing flavor has been our pleasant purpose for nearly thirty years in the making of Ariston Vanilla Extract.

The true value of vanilla extract—its strength and fine flavor—is in direct proportion to the quantity and quality of vanilla beans used in its preparation. Ariston Vanilla is, and always has been, made of the choicest beans that grow, used in quantity greater than standard requirements.



Recent sharp advances in the cost of vanilla beans have forced advances in the price of vanilla extract. We believe this situation is temporary and that, in time, prices will again be normal.

In the meantime, can you afford to use inferior vanillas, lowered in quality to avoid increase of price? Will a small saving be worth the sacrifice in your effort to satisfy the jaded appetite?

The extra strength and quality in Ariston Vanilla are higher in proportion than its extra cost. Its use is always a positive economy—in results per dollar, aside from its better flavor.

We stand firm in maintaining Ariston quality. To us that's the first consideration. And we believe you regard it the same way.

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This nurse is wondering if the heat has penetrated to the center of the package. She delivers doubtful dressings.



This is a SAFE NURSE. She takes no chances. She uses a Sterilizer control every time she sterilizes—she knows.

## YOUR HOSPITAL IS NOT A SAFE HOSPITAL

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## STERILIZER CONTROLS—DIACK

ARE USED  
TO PROVE

## HEAT PENETRATION

USED IN ALL EFFICIENT HOSPITALS

Safety Should Accompany Service.

100 FOR \$6.00

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## EFFICIENCY and ECONOMY



are responsible for the 400 SURGEON'S OPERATING VENTILITE installations that have been made in the past year.

Among the many institutions that are 100 per cent VENTILITE equipped may be mentioned:

Augustana Hospital	Chicago, Ill.	3 Ventilites
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Elizabeth Gen. Hospital	Elizabeth, N. J.	4 Ventilites
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Ventilites are designed to meet the intricate lighting demands of modern surgery. Strong, clear light—without heat or glare—may be spread over the operating field or diaphragmed into the smallest incision. No electrical changes are necessary as attachment is made to any light socket or outlet.

### OUR WARRANTY

Any SURGEON'S OPERATING VENTILITE may be returned, at our expense, within 10 days of installation, if it fails to deliver satisfactory illumination for any type of operation.

Lowest initial cost. Lowest operating cost. Unit complete, ready for instant operation.....\$97.50

JOHNSON VENTLITE COMPANY

732 Federal St.

Chicago, Ill.

Louisville, for the past six years, has been appointed superintendent of the hospital.

### Massachusetts

**Nurses' Home for House of Mercy Hospital.**—Plans are being prepared for a nurses' home for the House of Mercy, Pittsfield, to cost \$90,000.

**Eventide Home of Quincy.**—A new institution to be known as the Eventide Home of Quincy is to be erected as a home for the aged at Quincy.

**Resigns Position at Worcester State Hospital.**—Dr. Ransom H. Sartwell has resigned as assistant superintendent, Worcester State Hospital, Worcester, to become superintendent of the Rhode Island Infirmary at Cranston, R. I.

**Make Survey of Undernourished Children.**—A group of physicians from the Westfield Tuberculosis Sanitarium have just completed an extensive survey of the children at the camp for undernourished children operated by the Kiwanis Club of Pittsfield.

**Springfield Hospital Plant to be Surveyed.**—The trustees of the Springfield Hospital, Springfield, have engaged Dr. S. S. Goldwater, director, Mount Sinai Hospital, New York, N. Y., to make a survey of the hospital plant with a view toward its future development.

**Appointments to Massachusetts General Hospital.**—Drs. James Herbert Young and Joseph Garland have been appointed visiting physicians and Dr. Elie C. Romberg, visiting physicians to out-patients, on the pediatric service at the Massachusetts General Hospital, Boston, Mass.

### Michigan

**Home for the Friendless.**—Bids are being taken for the erection of a new \$75,000 building for the Home for the Friendless, Saginaw.

**Site Chosen for Psychopathic Hospital.**—St. Joseph's Mercy Hospital, Ann Arbor, has acquired a tract of eighty-eight acres of land three miles from the city for the purpose of building a psychopathic hospital.

### Minnesota

**Addition for Northwestern Hospital.**—Plans are being prepared for an addition to the Northwestern Hospital, Minneapolis.

**Elliott Memorial Cornerstone Laid.**—The cornerstone of the addition to the Elliott Memorial Hospital, Minneapolis, was laid October 1. The new building will have a capacity of 100 beds.

**Cornerstone of Todd Memorial Clinic Laid.**—The cornerstone of the Todd Memorial Clinic and the Cancer Institute at the University of Minnesota Hospital, Minneapolis, were laid October 1.

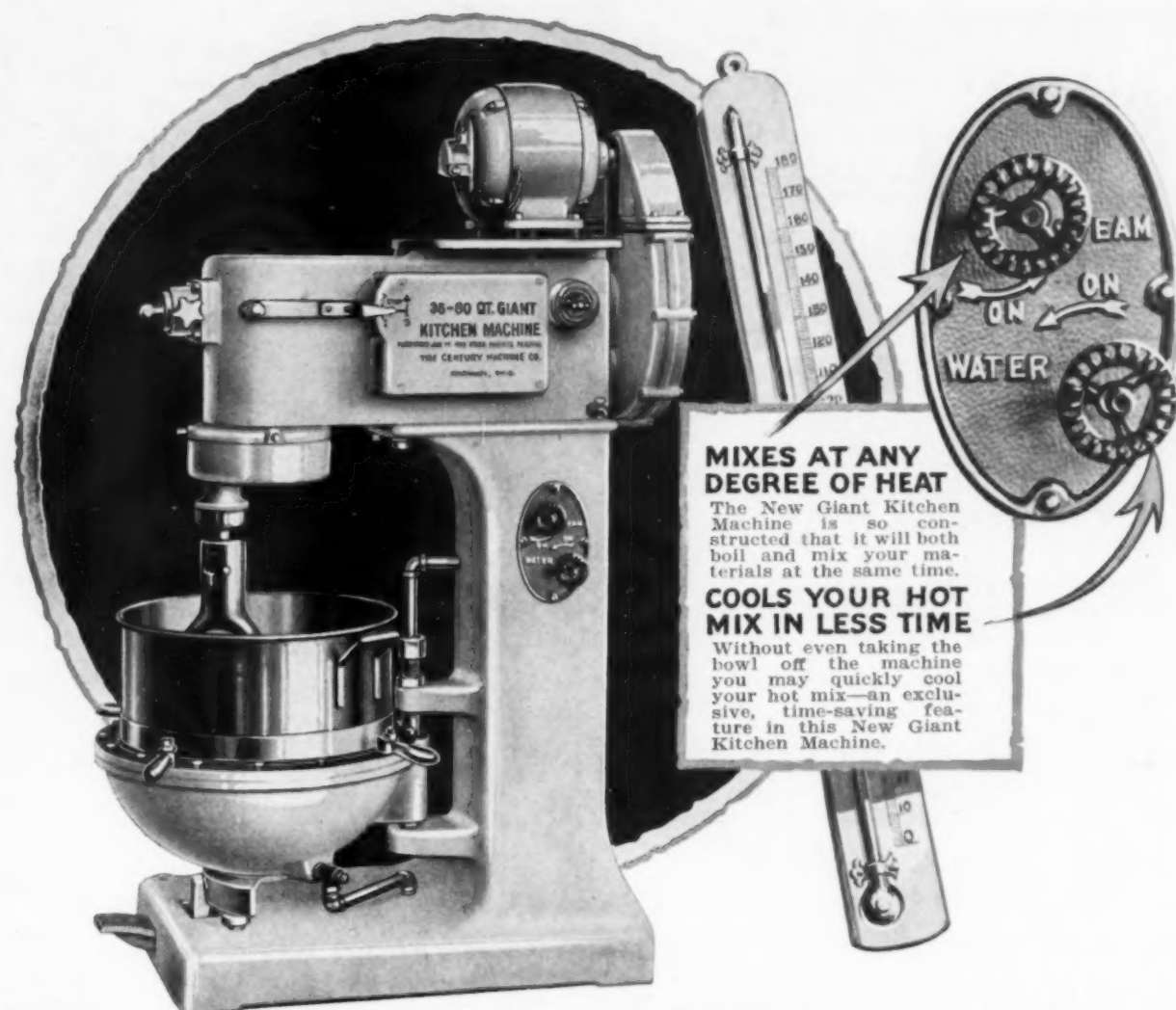
**Radio Fund for Hospital.**—Dr. J. K. Anderson, superintendent, Deerwood Sanitarium, Brainerd, is launching a drive for a radio fund with which to equip the institution with a model radio set for patients.

### Mississippi

**Tupelo Hospital Superintendent Resigns.**—Miss Mary Emma Smith, who for the last three years has been superintendent of the Tupelo Hospital, Tupelo, has resigned her position.

**St. Francis' Hospital Completed.**—St. Francis' Hospital, Wilmington, has just been completed and will soon be dedicated. The institution is owned by the Sisters of St. Francis of the Third Order.

**To Superintend Mississippi Baptist Hospital.**—Mrs. B. E. Golightly, formerly superintendent of the Birmingham



## New Giant 4 Speed Kitchen Machine

*with these improvements!*

stirs or mixes while keeping the batch at any degree of heat or cold

Absolutely noiseless operation.  
Ball Bearings throughout eliminate friction and wear.  
Spiral Gears running in oil bath.  
Lubrication required only once a year.  
Jacket around bowl for boiling and mixing simultaneously. Also used to cool batch while mixing.  
Centralized temperature control.  
2 Horse Power protected, ventilated motor.  
Single operating lever controls machine.  
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Patented beater lock—no screws, clamps or springs.  
Unbreakable wire whips.  
Convenient foot latch to lock or release bowl support.  
Bowl swings to either side.  
Unnecessary to raise or lower bowl.  
Driving Socket for food chopper, slicer and grater, coffee and spice mill, flour sifter, etc.  
Colander with largest straining area means faster work.  
Soup bowl with drain for continuous straining process.

In addition to other work, you may prepare custards, warm sponge cake doughs, cream sauces, fillers for eclairs, soups and gravy stocks and many other materials on this mixer. Potatoes and other vegetables can be kept piping hot while mashing—no longer need the chef stand over a hot stove stirring by hand.

Without even taking the bowl off, you may quickly cool your hot mix in this New Giant Kitchen Machine—the New Giant does so many things and does them so quickly, you will surely want to know all about it.

Write for descriptive circular and price on this New Giant Kitchen Machine.

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OAKLEY, CINCINNATI, OHIO

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Hospital Beds, Rugs,  
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Blankets, Sheets and Pillow Cases in Case  
Lots shipped direct from mill.

Special attention given to Nurses' Uni-  
form materials.

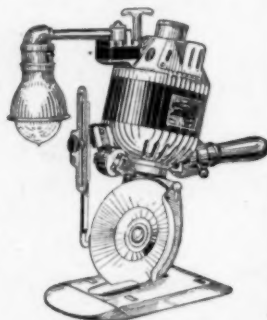
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Says a large Buffalo hospital using  
the Eastman Electric Cloth Cutting  
Machine for gauze dressings, cellu-  
cotton, and hospital  
garments. Hospitals  
estimate it saves  
from 75 to 90 per  
cent of the time re-  
quired to do the  
work by hand. Ask  
for a free demon-  
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**Eastman Machine Co., Buffalo, N. Y.**

Manufacturers of

**EASTMAN CUTTERS**

for Gauze Dressings, Cotton,  
and Hospital Garments

ham Infirmary, has been appointed superintendent of the  
Mississippi Baptist Hospital, Jackson.

**Missouri**

**Addition to Methodist Hospital.**—The Methodist Hos-  
pital, Springfield, is having plans drawn for an addition  
that will cost \$225,000.

**To Direct Pathological Laboratories.**—Dr. Frederick C.  
Narr, formerly of Pittsburgh, has become the director of  
the pathologic laboratories of the Research Hospital at  
Kansas City.

**Frisco Railroad to Have Hospital.**—The Frisco Railroad  
Hospital, Springfield, is being torn down to make room  
for a new \$400,000 hospital building which will accommo-  
date 100 patients.

**Dr. Campbell Leaves Kansas City General Hospital.**—  
Dr. Watson Campbell has resigned as pathologist of the  
General Hospital, Kansas City, to accept a similar posi-  
tion at Dr. Arthur E. Hertzler's Hospital, Halstead.

**Plan to Raise Funds for Burge Deaconess Hospital.**—  
An addition is being planned for the Burge Deaconess  
Hospital, Springfield. The addition will cost \$200,000  
and will provide for 100 patients. A drive is being un-  
dertaken to obtain pledges to the amount of the expendi-  
ture from the citizens of Springfield.

**Columbia Hospital Opens.**—The new \$250,000 hospital  
of the University of Missouri was opened to the public  
September 21. The new hospital increases the capacity  
of the old Parker Memorial Hospital by seventy-five beds.  
The hospital was planned by Dr. Guy L. Noyes, dean  
of the school of medicine, University of Missouri, Colum-  
bia.

**Evacuation Hospital Appointments.**—The following phy-  
sicians have been appointed on the staff of evacuation  
hospital No. 67 (Missouri Baptist Sanitarium Unit, St.  
Louis), organized reserves: commanding officer, Lieut.-  
Col. William H. Luedde; executive officer, Major Edward  
Lee Dorsett; chief of surgical service, Lieut.-Col. Willard  
Bartlett; chief of medical service, Lieut.-Col. Oliver H.  
Campbell.

**Trachoma Clinic Held at Columbia.**—A trachoma clinic  
was held at Columbia September 24-25 by Dr. R. L.  
Russell, director of the division for the prevention of  
blindness, in cooperation with a representative of the  
U. S. Public Health Service. The private railroad is  
equipped with facilities for treating trachoma and will  
be routed to fifteen counties in the state and trachoma  
prevailed to some degree in all of them.

**Montana**

**New Building for Kennedy Deaconess Hospital.**—A  
building is in the course of construction for the Kennedy  
Deaconess Hospital, Havre.

**New Jersey**

**State Hospital Plans New Buildings.**—Plans have been  
completed for a group of buildings at the New Jersey  
State Hospital, Morris Plains.

**Appointed Medical Director.**—Dr. Frank J. McLoughlin,  
has been appointed medical director of St. Francis Hos-  
pital, Jersey City, to succeed the late Dr. John J. Mooney.  
Dr. McLoughlin will also continue as visiting surgeon on  
the staff of St. Mary's Hospital, Hoboken.

**Atlantic City Hospital Plans Reconstruction.**—Dr. S. S.  
Goldwater, director, Mount Sinai Hospital, New York,  
N. Y., is acting in an advisory capacity in relation to the  
reconstruction of the Atlantic City Hospital, Atlantic City,  
N. J. Architectural plans have been prepared by S. Hud-

# RODDIS DOORS



Architects:  
Jos. Evans Sperry

Contractors:  
Frainie Bros. &  
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## UNION MEMORIAL HOSPITAL Baltimore, Md.

**I**N THIS splendid new hospital, are hundreds of Roddis Flush Doors—each one sanitary, soundproof, fire-resisting. And because these Doors are made by Roddis, in the exclusive Roddis type of construction, they will outlast the building itself.

They are *five-ply*, for greatest strength and durability. Around the top, bottom and both sides runs a hardwood edge-strip one-half inch thick which securely seals the softwood core and keeps out all moisture. The entire Door is forever cemented together with rock-like waterproof glue. Never can it sag, warp, shrink, swell, separate, check, nor lose its enduring beauty.

Roddis Flush Doors are capable of so complete service that they can be and are guaranteed without condition. This long life is built into the Doors; it is not to be told by mere surface inspection. Hence, leading architects and informed hospital builders make doubly sure their doors are made by Roddis. The name and reputation of the maker are the sole assurance of lasting door satisfaction.

Our 78-page catalog is worth your study. It shows why more Roddis Doors are being installed in hospitals than any other. It will be mailed upon your request.

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## Twin Disc All Purpose Floor Machine

KEEPS HOSPITAL FLOORS  
CLEAN AND SANITARY

DISCS REVOLVING IN OPPOSITE DIRECTIONS MAKE MACHINE SELF-CONTROLLED

EASIER TO OPERATE THAN A VACUUM  
CLEANER

Light in weight.  
Instantly ready for use.  
No experience necessary.  
Cleans, scrubs, polishes.  
Old hand method eliminated.  
Low cost of operation.  
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MADE IN 5  
SIZES FOR  
EVERY  
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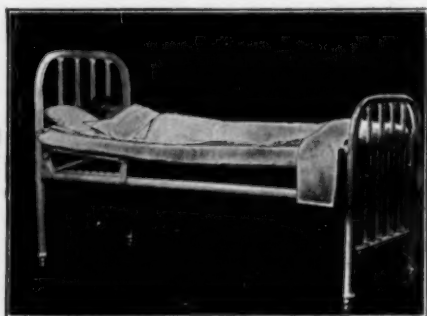


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The Vit-O-Net Electrical Blanket is the solution to the hot pack problem. Far superior to old fashioned hot pack methods. Its soothing heat causes a profuse but gentle diaphoresis. Stimulates circulation. Does not weaken. Endorsed and used by scores of prominent hospitals for Pneumonia, Eclampsia, Nephritis, Post-Operative, Uremia, Shock, Rheumatism, etc. Instantly ready for bedside or operating table. Only one nurse required to operate. Soon pays for itself in saving of nurse's time and wear and tear on ordinary blankets.

Write for complete information  
and special discount to hospitals

**VIT-O-NET MFG. CO.**

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son Vaughn, H. A. Stout, and J. Vaughn Mathis, architects, Atlantic City.

**Building Program of New Beth Israel Hospital.**—The building program for the New Beth Israel Hospital, Newark, for which a sum approximating \$2,000,000 has recently been raised, calls for the erection of a hospital building with an initial capacity of from 250 to 300 beds. Dr. S. S. Goldwater, director, Mount Sinai Hospital, New York, N. Y., is consultant and Mr. Frank Grad, Newark, architect.

### New York

**Castle Point Hospital Opens.**—The new Castle Point Hospital, Chelsea, was opened September 15.

**Lakeview Sanitarium Changes Name.**—The name of the Lakeview Sanitarium, Troy, has changed to the Pawling.

**To Superintend Bronx Hospital.**—Mr. William S. Sindey has accepted the superintendency of the Bronx Hospital, New York.

**Addition to Albany Hospital.**—Plans are being drawn for an addition to Albany Hospital, Albany, which will cost \$750,000.

**Nurses' Home for St. Vincent's Hospital.**—Work is under way on the new nurses' home for St. Vincent's Hospital, New York.

**New Home for St. Mark's Hospital of New York City.**—Plans are being prepared for a new home for St. Mark's Hospital, New York.

**Clinic for Industrial Diseases.**—A clinic for the diagnosis, study and treatment of industrial diseases is being maintained at the Reconstruction Hospital, New York.

**Founder of Dobbs Ferry Hospital Dies.**—Dr. Champion H. Judson, founder of the first hospital in Dobbs Ferry, in 1893, died at his home in Dobbs Ferry, September 6.

**Attending Physician to Willard Parker Hospital.**—Dr. Carlisle S. Boyd has been appointed attending physician to the Willard Parker and Reception Hospital, New York.

**New Building for Staten Island Hospital.**—Plans are being prepared for a new building for the Staten Island Hospital, New York. It is to be a five-story building to cost \$200,000.

**Vassar Hospital Dedicated.**—The new \$800,000 pavilion of the Vassar Hospital, Poughkeepsie was dedicated September 18. Dr. George E. Vincent, Rockefeller Foundation, gave the dedicatory address.

**Elks to Establish Home for Infantile Paralysis Victims.**—The Elks lodge of Schenectady, has announced its intention of establishing a home for infantile paralysis victims in Schenectady.

**Two Branch Laboratories for Montgomery County.**—Two branch laboratories in Montgomery County are being established, one at St. Mary's Hospital and one at the Montgomery Sanatorium. Plans are being made to have all types of routine diagnostic examinations performed there.

**Two Veterans' Hospitals Open.**—The Veterans' Bureau Hospital, Castle Point, was opened September 15. Veterans' Bureau Hospital No. 98, Beacon, was recently opened. The latter which is in charge of Dr. James E. Dedman, has accommodations for 450 tuberculous patients.

**Free Mental Clinics at Binghamton State Hospital.**—Dr. William C. Garvin, superintendent, State Hospital, Binghamton, has announced the establishment of free mental clinics by that institution in Boone, Chenango, Cortland, Chemung, Delaware, Otsego, Schoharie, Madison and Tompkins counties.